

**Adult TB Self-Assessment and Screening Form**

*Must be completed by all undergraduate and graduate students within 6 months of the first day of classes.  
Submit the completed form to Magnus Health for review.*

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

Student ID: \_\_\_\_\_

<b>TB Risk Assessment</b>	<b>Yes</b>	<b>No</b>
1) Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean, or the Middle East? In what country were you born? _____		
2) In the past 5 years, have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean, or the Middle East for <b>more than one month</b> ?		
3) In the last 2 years, have you lived with or spent time with someone who has been sick with TB?		
4) Do you have (or have you had) any of these medical conditions? Diabetes                      Kidney disease HIV infection                Colitis Cancer                         Stomach or intestine surgery Rheumatoid arthritis		
5) Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?		
6) In the past 1 year, have you injected drugs that your doctor did not prescribe?		
7) Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility? (example: nursing home, substance abuse treatment, rehabilitation facility)		

**If you answer “yes” to any of the questions above, you may be at increased risk for TB infection. Please give this form to your medical provider.**

## TB Risk Assessment and Screening Form

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

### TB History and Triage (to be completed by a medical provider)

TB History	Yes	No
1) Has the person had a TB test (skin test or blood test)? TB test result: Positive Negative Unknown TB test date: _____ (MM/YY) Where _____ (facility)		
2) Did the person get a chest x-ray after the TB test? X-ray result _____ X-ray date: _____ (MM/YY)		
3) Did the person take medication for TB infection?		
4) Does the person remember being sick with TB? If yes, when _____ (MM/YY) Where: Country _____ State: _____		

Triage Plan	
	<b>Person has TB risk and has one or more TB symptoms:</b> Refer the person for <b>prompt clinical evaluation</b> including a chest x-ray to rule out active TB
	<b>Person has TB risk, no symptoms and has no history of previous positive TB test:</b> Test for TB infection or refer for testing and evaluation
	<b>Person has a history of previous positive TB test, but has no evidence of treatment:</b> Refer for TB evaluation and treatment

TB Test Documentation
Tuberculin Skin Test (TST) plant date: _____ (MM/DD/YY) / TST read date: _____ (MM/DD/YY)
TST Result: _____ (Millimeters of Induration) / TST Interpretation: Positive* Negative Unknown
Interferon-Gamma Release Assay (IGRA) performed: ___ / ___ / ___ (MM/DD/YY)
IGRA Interpretation: Positive* Negative Indeterminate/Borderline (requires repeat test)
<b>* Report all persons with positive TB test to the Massachusetts Department of Public Health (DPH)</b> <a href="http://www.mass.gov/eohhs/gov/departments/dph/programs/id/isis/case-report-forms.html">http://www.mass.gov/eohhs/gov/departments/dph/programs/id/isis/case-report-forms.html</a>

Additional comments:

Medical Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### Instructions to Medical Providers

The TB risk assessment and screening form aims to identify persons with **increased risk for TB** who may require further testing and evaluation. Persons born in countries where TB is common are at increased risk for TB (especially, but not limited to those who arrived in the last 5 years).

The **TB Self-Assessment of TB Risk section** can be completed by the patient/client/guardian alone or with the provider's assistance. The provider should review the information and discuss TB risks, symptoms, previous TB testing, and treatment with the patient/client.

#### **If the person with TB risk describes or exhibits symptoms suggestive of possible active TB:**

- Isolate the patient/client immediately (if possible) and have the patient/client wear a mask.
- Refer the patient/client for prompt clinical evaluation including a chest x-ray. Ensure that the patient/client wears a mask during transport to the provider.
- Consult the Massachusetts Department of Public Health/Bureau of Infectious Disease/ Division of Global Populations and Infectious Disease Prevention at 617-983-6970.

#### **If the person has a history of TB or TB risk, but has no symptoms suggestive of TB:**

- Educate the patient/client about signs and symptoms of TB and should such symptoms develop, instruct them to seek medical follow-up.
- Consider testing the patient/client for TB infection or refer to a primary care provider.
- Consult the Massachusetts Department of Public Health/Bureau of Infectious Disease, Division of Global Populations and Infectious Disease Prevention at 617-983-6970, if needed.

#### **Resources**

Information about TB evaluation, testing and treatment can be found at <http://www.cdc.gov/tb/> and <http://www.mass.gov/dph/cdc/tb>

Guideline on the use of Interferon-Gamma Release Assay can be found at <http://www.mass.gov/eohhs/gov/departments/dph/programs/id/tb/testing-screening/>

Cases of suspect active or confirmed cases of active TB and TB infection are reportable to the Massachusetts Department of Public Health per Chapter 105, Code of Massachusetts Regulations (CMR), Section 300.000: Reportable Diseases, Surveillance, and Isolation & Quarantine Requirements.)

<http://www.mass.gov/eohhs/gov/departments/dph/programs/id/epidemiology/rdiag/reporting-diseases-and-surveillance-information.html>

DPH-supported TB clinics <http://www.mass.gov/eohhs/docs/dph/cdc/tb/regional-clinic-list.pdf>