HealthCare
University Health Service
EMPLOYEE HEALTH

Integrated Tuberculosis (TB) Screening and Risk Assessment Form for Healthcare College Students

Student Name: _____ **Date:** _____

Date of Birth: _____ **Student ID:** _____

Healthcare college: _____ **Select One: New Student** ☐ **Returning Student** ☐

Phone Number: _____

Please note: To maintain confidentiality, this questionnaire is part of your medical record. Your responses are protected by HIPAA and will not be shared without your authorization.

1. Date of most recent TB test: _____ **OR** I have never completed a TB test/ I Don't Know ☐
2. Provide results of most recent TB test.
3. Have you ever had a positive TB test (skin test or blood test)?
   - a. YES - If **yes** move to section A. Complete section A ONLY
   - b. NO - if **no** move to section B. Complete section B ONLY
   - c. I don't know - if **I don't know** move to section B. Complete section B ONLY

SECTION A

A1) Date of positive TB test? _____

A2) Attach results of positive test.

A3) Did you have a chest x-ray after the positive TB test? YES NO

If yes, provide results

A4) Did you receive any treatment following the positive TB test? YES NO

If yes, provide details: _____

A5) Do you currently have any of the following symptoms:

a.	Unexplained fever for more than 3 weeks	YES	NO
b.	Cough for more than 3 weeks with sputum production	YES	NO
c.	Bloody sputum	YES	NO
d.	Unintended weight loss >10 pounds	YES	NO
e.	Drenching night sweats	YES	NO
f.	Unexplained fatigue for more than 3 weeks	YES	NO

A6) I certify that if I ever experience symptoms of a productive cough for more than 3 weeks, unexplained fever or fatigue for more than 3 weeks, bloody sputum, drenching night sweats, or unexplained weight loss of more than 10 pounds, I will contact UHS Student Health. YES NO

A7) If you previously had a positive TB test and you did not receive complete treatment, your infection could progress to active TB, particularly if you also have one or more of the following risk factors: cancer, lung disease, tobacco use, recreational drugs use, uncontrolled diabetes, planned or current immunosuppression, HIV infection, receipt of organ transplant, chronic steroids (the equivalent of prednisone > 15 mg/day for > 1 month), chemotherapy agents, or TNF alpha antagonist (infliximab, etanercept, or other), and older age.

A8) I certify that I understand the above paragraph (paragraph A7). YES NO

Student Signature: _____ Date: _____

Student Health RN Signature: _____ Date: _____

SECTION B

B1) Have you **ever** spent more than 30 days in a country with an elevated TB prevalence? This includes all countries outside of the United States except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand. YES NO
If yes, what was the date? _____

B2) Have you **ever** had close contact with anyone who had active TB? YES NO
If yes, what was the date? _____

B3) Have you lived in or provided care in a setting with an elevated TB risk (nursing home, prison, homeless shelter, etc.)? YES NO
If yes, what was the date? _____

B4) Have you **ever** been diagnosed with active TB disease? YES NO
If yes, what was the date? _____

B5) Have you **ever** been diagnosed with latent TB infection (LTBI)? YES NO
If yes, what was the date? _____

B6) Have you **ever** lived as an unhoused person? YES NO
If yes, what was the date? _____

B7) Have you previously injected recreational drugs? YES NO
If yes, when was the last date? _____

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B8) Do you **currently** have any of the following symptoms:

a.	Unexplained fever for more than 3 weeks	YES	NO
b.	Cough for more than 3 weeks with sputum production	YES	NO
c.	Bloody sputum	YES	NO
d.	Unintended weight loss >10 pounds	YES	NO
e.	Drenching night sweats	YES	NO
f.	Unexplained fatigue for more than 3 weeks	YES	NO

Student Signature: _____ Date: _____

Student Health RN Signature: _____ Date: _____