stepworks

Tuberculosis (TB) Risk Assessment

Name: _____ Date of Birth: ____ / ____ / ____ County of Residence: _____

Job Title: _____ Facility Location: _____

Please check all options below that apply to you.

Active TB Symptom Screening

- ☐ cough for more than 3 weeks
  - ☐ productive ☐ non-productive
- ☐ coughing up blood
- ☐ fever of 100° for over 2 weeks
- ☐ unexplained weight loss (more than 10 pounds)
- ☐ poor appetite
- ☐ **unusual** or heavy sweating at night
- ☐ **unusual** weakness or extreme fatigue
- ☐ none of these apply

If you checked any box above, please explain:

Risk for Developing TB if Infected

- ☐ HIV positive ☐ at risk for HIV, but status unknown
- ☐ inject illicit drugs
- ☐ 10% below ideal body weight
- ☐ currently taking immunosuppressive drugs (Remicade, Humira, Prednisone, etc.)
- ☐ currently use tobacco and/or alcohol
- ☐ have or have had any of the following:
  - ☐ diabetes
  - ☐ kidney disease
  - ☐ cancer
  - ☐ stomach or intestinal surgery
  - ☐ rheumatoid arthritis
  - ☐ colitis
- ☐ none of these apply

Risk for Acquiring TB

- ☐ lived or spent time with someone with TB
- ☐ been in another country for 3 or more months where TB is common and have been in the US for less than 5 years
- ☐ have injected illegal drugs
- ☐ have lived or worked in a prison, jail, homeless shelter, or long-term care facility
- ☐ none of these apply

Comments:

History of TB Testing

- ☐ had BCG vaccine (year: _____)
- ☐ previous positive TB test (year:_____)
- ☐ had chest x-ray (date: _____ / _____ / _____)
  - ☐ result was normal ☐ result was abnormal
- ☐ chest x-ray within last 2 months
  - ☐ result was normal ☐ result was abnormal
- ☐ taken TB medication (year: _____)
- ☐ completed TB medication (list medications and duration under "Comments" to the left)
- ☐ none of these apply

I hereby authorize Stepworks to administer a TB test. I understand that this information will remain a part of my employee health record and will not be released without my knowledge and written consent except for new findings which are required to be reported to the local health department having jurisdiction.

Signature: _____ Date: ____ / ____ / ____

Office Use Only

- ☐ referred for chest x-ray ☐ administered TB skin test ☐ referred for medical evaluation
- ☐ filed with HR, no TB test needed ☐ other: _____

Screener's Name: _____ Signature: _____ Date: ____ / ____ / ____

Stepworks, LLC
P.O. Box 6209, Elizabethtown, KY 42702 | Phone: 1-800-545-9031

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