



Northwestern Polytechnic University

Tuberculosis (TB) Risk Assessment To be completed by a Health Care Provider

Name of Student: _____

Date of Birth: _____

If there is a "Yes" response to any of the questions below, further TB evaluation is required; please complete the attached "Clinical Tuberculosis Assessment by a Health Care Provider".

TUBERCULOSIS RISK FACTORS

1. **One or more signs and symptoms of TB** Yes No

(prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue)

For TB symptoms or abnormal chest x-ray consistent with active TB disease → *Evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.*

2. **History of positive TB test or TB disease** Yes No

3. **Foreign-born person from a country with an elevated TB rate** Yes No

(Any country except the United States of America, Canada, Australia, New Zealand, or Western and North European countries)

4. **Travel to a country with an elevated TB rate for more than one month** Yes No

5. **Close contact with a person known or suspected to have active TB disease** Yes No

6. **Immunosuppression** Yes No

(HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication)

No TB risk factors identified, no further TB evaluation needed

TB risk factor(s) identified, referred for further TB evaluation

Provider Name:

Provider Signature:

Provider Address and Contact Information:

Assessment Date: