

## Tuberculosis (TB) Screening and Risk Assessment Form for Newly Hired

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

Facility Name: \_\_\_\_\_ Phone \_\_\_\_\_

1. What position are you hired for? \_\_\_\_\_ What is your start date? \_\_\_\_\_
2. Have you EVER spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, and New Zealand.  
 YES I have been in a foreign country for  $\geq 30$  days (**not including those listed above**)  
**Name of Countries visited:** \_\_\_\_\_  
 NO I have not been in any country for  $\geq 30$  days **except the ones listed above**
3. Have you had close contact with anyone who had active TB since your last TB test?  
**Circle that applies** YES / NO
4. Do you currently have any of the following symptoms: **Circle that applies**
  - a. YES / NO unexplained fever for more than 3 weeks
  - b. YES / NO cough for more than 3 weeks with sputum production
  - c. YES / NO bloody sputum
  - d. YES / NO unintended weight loss >10 pounds
  - e. YES / NO drenching night sweats
  - f. YES / NO unexplained fatigue for more than 3 weeks
5. Have you ever been diagnosed with active TB disease? **Circle that applies**  
YES / NO
6. Have you ever been diagnosed with latent TB infection *or* had a positive skin test *or* a positive blood test for TB?  
**Check that applies**  
 YES one or more of these is true for me  
 NO none of these is true for me
7. Have you been treated with medication for TB *or* for a positive TB test (eg, taken "INH")?  
**Circle that applies** YES / NO  
  
If YES, what year, with which medication, for how long, and did you complete the treatment course?  
\_\_\_\_\_
8. Do you have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health provider) **Circle that applies**  
 YES, one or more of these is true for me  
 NO, none of these is true for me

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Occupational Health Reviewer Signature Date

\_\_\_\_\_  
Manager/Designee Date

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