INTERNAL USE ONLY
☐ ELI ☐ OISS ☐ SA
Insurance:

Tuberculosis (TB) Risk Assessment

Campus Health Center

Name:_____ **Today's Date:** ____/____/____
LAST FIRST *MONTH DATE YEAR*

Address:_____
STREET CITY STATE ZIPCODE

Birth Date: ____/____/____ **Birth Country**:_____
MONTH DATE YEAR

Phone: (____) ____ – ____ **WSU Email:** _____**@wayne.edu**
(2 letters and 4 numbers ex: ab1234@wayne.edu)

Wayne State ID# __ __ __ __ __ __ __ __ __ **Contact By:** ☐ Phone ☐ Email

Yes	No	
☐	☐	Have you ever had a positive TB skin test? If yes, were you treated with medication? ☐ No ☐ Yes How long? _____
☐	☐	Have you ever been vaccinated with BCG (TB vaccine)? If yes, when? _____
☐	☐	Have you had any of these symptoms? *(check all that apply)* ☐ Cough for longer than 3 weeks ☐ Chronic fever ☐ Coughing up blood or blood in sputum ☐ Night sweats for longer than 3 weeks ☐ Unexplained weight loss
☐	☐	Have you had recent close contact with someone with infectious TB disease (family member, co-worker, roommate, etc.)?
☐	☐	Have you ever lived with someone who has had a positive PPD test?
☐	☐	Have you ever had an abnormal chest x-ray?
☐	☐	Have you tested positive for HIV or AIDS?
☐	☐	Have you ever had an organ and/or bone marrow transplant?
☐	☐	Have you ever taken medications that affect your immune system?
☐	☐	Have you spent 30 or more consecutive days in a country other than the United States? If yes, where and when? Country: _____ Year: _____
☐	☐	Do you live or work in any of the following settings: *(check all that apply)* ☐ Correctional facility (prison) ☐ Long term facility ☐ HIV/AIDS residence ☐ Hospital ☐ Homeless shelter ☐ Correctional facility (prison) ☐ Laboratory (specify type): ☐ Other health care facility _____

☐ WAIVED DATE:	IGRA ☐ T-Spot DATE: TIME: ☐ DMC	Chest X-Ray ☐ Referral DATE:

Responsible Provider Initials: _____

Updated: March 4, 2015