Risk Assessment Tool for Tuberculin Skin Test (TST)

Reason for Visit

Please specify __________________________________________

Risk Factors

High Risk
Contact to TB case
HIV-positive
At high-risk for HIV infection (unknown status)
Fibrotic changes on chest x-ray consistent with prior TB
Organ transplant recipient
Other immunosuppression factors (e.g., receiving equivalent of ≥ 15 mg/d of prednisone for one month or longer)

Increased Risk for TB
Documented TST conversion within the last two years
Recent (within the last five years) immigrant from high TB-prevalent (endemic) country
Taking TNF blocker medications for Rheumatoid Arthritis (Remicade/Infliximab, Enbrel, Humira,)
Injection and Non-Injection drug use
Resident/employee of high-risk congregate settings (e.g., incarcerated – currently or within the past two years, nursing home, hospital)
Mycobacteriology laboratory personnel
Children ≤ four years or infants, children, adolescents exposed to adults at high risk for TB disease
Person with the following conditions
Silicosis
Diabetes mellitus
Chronic renal failure
Cancer of the head, neck, or lung
Leukemias/lymphomas
Low body weight (≥ 10% of below ideal body weight)
Gastrectomy/jejunoileal bypass
Socio-economic predictors of exposure based on local morbidity data

At risk for TB? (based on above risk factors)

If yes, please complete the information below.

History

Previous TST
If yes, Where? ____________ When? ____________ Result ________ mm

Previous treatment for TB disease
When? ____________ Where? ____________ Months of treatment ________
Medications

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### Previous treatment for LTBI

When?  | Where?  | Months of treatment
---|---|---

### TB medications

- [ ] Yes
- [ ] No

### History of BCG

When?  | Where?  | Date of last dose
---|---|---

- [ ] Yes
- [ ] No

### Symptoms of TB disease

- **Cough** – duration ≥ three weeks
  - [ ] Yes
  - [ ] No
- **Hoarseness** – duration ≥ three weeks
  - [ ] Yes
  - [ ] No
- **Hemoptysis**
  - [ ] Yes
  - [ ] No
- **Fever**
  - [ ] Yes
  - [ ] No
- **Chills**
  - [ ] Yes
  - [ ] No
- **Night sweats**
  - [ ] Yes
  - [ ] No
- **Appetite loss**
  - [ ] Yes
  - [ ] No
- **Weight loss**
  - [ ] Yes
  - [ ] No
- **Easily fatigued**
  - [ ] Yes
  - [ ] No

### Results and Recommendations

**Client advised that if TST is positive, he/she will be evaluated for treatment for LTBI**

- [ ] Yes
- [ ] No

**Discussed the need to take medication for four, six or nine months (until treatment is completed)**

- [ ] Yes
- [ ] No

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**If my tuberculin skin test is positive, I agree to take TB medication for treatment of latent TB infection as directed unless medically contraindicated.**

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### TST administered:

- [ ] Yes
- [ ] No

**Site:**

- [ ] LFA
- [ ] RFA
- [ ] Other (please state)

**Manufacturer:**

- [ ] Tubersol
- [ ] Aplisol
- [ ] Lot No: [ ]

**TST read:**

- [ ] Yes
- [ ] No

**Documented converter within the last two years?:**

- [ ] Yes
- [ ] No

**If positive, chest x-ray done:**

- [ ] Yes
- [ ] No

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**Candidate for treatment of LTBI**

- [ ] Yes
- [ ] No

**Recommended treatment:**

- [ ] None
- [ ] INH 9 months
- [ ] INH 6 months
- [ ] Other (please specify)

**Comments:**

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**Signature of Nurse**

**Printed Name of Nurse**

**Title of Nurse**

**Date**

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**NAME**

**ID #**

**DOB**

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