SAN FRANCISCO BAY UNIVERSITY

San Francisco Bay University
161 Mission Falls Lane
Fremont, CA 94539

www.sfbu.edu
Phone: 510.803.SFBU

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:

SAN FRANCISCO BAY UNIVERSITY
San Francisco Bay University
161 Mission Falls Lane
Fremont, CA 94539
www.sfbu.edu
Phone: 510.803.SFBU

Clinical Tuberculosis Assessment by Health Care Provider

Clinicians should review and verify the information in the Tuberculosis (TB) Screening Questionnaire (attached). Persons answering YES to any questions in the TB Screening Questionnaire should receive either a Mantoux Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. **For patients with no history of TB treatment, provider must complete Section I (p. 1-3). For patients with a history of prior or current TB treatment (for active disease or latent infection), provider must complete Section II (p. 4-7).**

History of a positive TST or IGRA? (If yes, provide copy of laboratory report)	**Yes _____ No _____**
History of BCG vaccination? (If yes, IGRA is preferred)	**Yes _____ No _____**
History of prior or current TB Treatment? (*If yes, proceed to section II*)	**Yes _____ No _____**

SECTION I. No History of Prior or Current TB Treatment

1. TB Symptom Check

Does the student have any of the following signs or symptoms of active pulmonary tuberculosis disease?

If yes**, check below **and** evaluate to exclude active tuberculosis disease including (1) TB test, (2) chest x-ray, and (3) sputum evaluation**. GO TO SECTION II.

- ❑ Cough > 2 weeks
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

***If no**, proceed to TB test*

2. TB Test: Tuberculin Skin Test (TST) *or* Interferon Gamma Release Assay (IGRA)

Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)*

Date Placed: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration *Interpretation: positive____ negative____

***Interpretation guidelines**

≥ 5 mm induration is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

San Francisco Bay University
161 Mission Falls Lane
Fremont, CA 94539

www.sfbu.edu
Phone: 510.803.SFBU

≥ 10 mm is positive for individuals not listed above (California guidelines)

Interferon Gamma Release Assay (IGRA) – <u>ATTACH COPY OF LABORATORY REPORT</u>

Collection date: ____/____/____
M D Y

Method: Quantiferon Gold (QFT)____ T-SPOT____ other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-SPOT only)

If initially indeterminate or borderline, repeat the test and document below:

Collection date: ____/____/____
M D Y

Method: Quantiferon Gold (QFT)____ T-SPOT____ other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-SPOT only)

3. Chest x-ray: (Required if TST or IGRA is positive) – <u>ATTACH COPY OF RADIOLOGY REPORT</u>

Date of chest x-ray: ____/____/____ Interpretation: normal____ abnormal_____
M D Y

- **If chest X-ray is normal, proceed to I (4) "Management of latent TB infection"**
- **If chest X-ray is abnormal consistent with active TB, further TB evaluation is required. Go to Section II, Evaluation for Students with Symptoms or Signs of TB Disease**

4. Management of Latent TB Infection (LTBI)

All students with a positive TST or IGRA who have been fully evaluated and active disease has been ruled out should be treated for LTBI.

___Student accepts treatment (complete section II) ___ Student declines treatment

San Francisco Bay University
161 Mission Falls Lane
Fremont, CA 94539

www.sfbu.edu
Phone: 510.803.SFBU

Provider Attestation

By signing below, the evaluating provider attests that: (1) The student has no symptoms or signs of active TB and (2) the student is not currently infectious for TB.

Provider Name (Please Print)	Provider Signature	Date

Provider Address	Provider Telephone Number

San Francisco Bay University
161 Mission Falls Lane
Fremont, CA 94539

www.sfbu.edu
Phone: 510.803.SFBU

SECTION II. Evaluation for Students with Symptoms or Signs of TB Disease OR History of Prior or Current Treatment for TB Infection or Disease

Complete evaluation or review applicable to student's TB status

Required evaluation	**Symptoms or signs of active TB**	**Currently on treatment for TB disease**	**Prior history of TB disease, treatment completed**	**Currently on treatment for LTBI**	**Prior history of completed treatment for LTBI**	**Prior history of positive TB test, no treatment**
Provider review of symptoms *(section 1)*	X	X	X	X	X	X
Provider documentation of specific treatment details *(section 2)*		X	X	X	X	
TB testing	X	X		X		
Chest x-ray within 6 months *(section 3)*	X	X	X	X		X
3 sputa for AFB smear, current *(section 4)*	X	X	X			
Prior chest x-ray records *(section 5)*		X	X	X	X	X
Prior sputum AFB smear and culture results *(section 5)*		X	X			
Provider attestation that student has no symptoms or signs of active TB			X	X	X	X
Provider attestation that student is not currently infectious for TB	X	X	X			
Clinician reports TB case to Public Health within 1 working day		X				
Student to bring all original TB diagnostic, microbiology, x-ray and treatment records		X	X			
Student to bring copies of chest and other radiographic images		X	X			

San Francisco Bay University
161 Mission Falls Lane
Fremont, CA 94539

www.sfbu.edu
Phone: 510.803.SFBU

1. TB Symptom Check

Does the student have any of the following signs or symptoms of active pulmonary tuberculosis disease?

***If yes**, check below **and** evaluate to exclude active tuberculosis disease including (1) TB test, (2) chest x-ray, and (3) sputum evaluation.*

- ❑ Cough >2 weeks
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever

2. TB Test: Tuberculin Skin Test (TST) *or* Interferon Gamma Release Assay (IGRA)

Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)*

Date Placed: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration *Interpretation: positive____ negative____

Interferon Gamma Release Assay (IGRA) – ATTACH COPY OF LABORATORY REPORT

Collection date: ____/____/____
M D Y

Method: Quantiferon Gold (QFT)____ T-SPOT____ other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-SPOT only)

If initially indeterminate or borderline, repeat the test and document below:

Collection date: ____/____/____
M D Y

Method: Quantiferon Gold (QFT)____ T-SPOT____ other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-SPOT only)

San Francisco Bay University
161 Mission Falls Lane
Fremont, CA 94539

www.sfbu.edu
Phone: 510.803.SFBU

3. Treatment Details

Treatment for (select one): _____ Active TB Disease or _____ Latent TB Infection

Date Treatment Initiated: ____/____/____
M D Y

Date Treatment Completed (or anticipated completion date): ____/____/____
M D Y

Student's Current Weight: _____ (kg)

Name of Medication	Strength (mg)	Number of Tablets	Frequency (qd, biw, tiw, etc.)	Total Dosage	Route (PO, IV, IM)	Date Started	Date Stopped
Isoniazid							
Rifampin							
Rifamate							
Rifabutin							
Pyrazinamide							
Ethambutol							
Vitamin B-6							

3. Chest and other imaging: (Chest x-ray required within 6 months of start of term) – <u>ATTACH COPY OF RADIOLOGY REPORTS</u>

Date of Imaging (Month/Day/Year)	Anatomical region/image type, e.g., chest x-ray, chest CT	Findings	Interpretation (normal, abnormal)

San Francisco Bay University
161 Mission Falls Lane
Fremont, CA 94539

www.sfbu.edu
Phone: 510.803.SFBU

4. Microbiology: AFB Smear and Culture – <u>ATTACH COPIES OF LABORATORY RESULTS</u>

Collection date	Specimen type	Smear result	Culture result	Susceptibility results

5. Provider Attestation: By signing below, the evaluating provider attests that: (1) The student has no symptoms or signs of active TB (or if currently under treatment for active TB, is asymptomatic) and (2) the student is not currently infectious for TB.

Provider Name (Please Print) _____ Provider Signature _____ Date _____

Provider Address _____ Provider Telephone Number _____