Cooper University Health Care

TB Risk Assessment Questionnaire

☐ Cooper University Hospital
☐ Cooper University Off-Site

Department: _____

Team Member: _____ **D.O.B:** _____

	Questions:	Yes	No	Unsure
1.	Have you ever had a **POSITIVE** tuberculin skin test?	☐	☐	☐
	a. What year was the positive test? _____ Reaction in millimeters (if known) _____	☐	☐	☐
	b. Did you ever take medication for a positive tuberculin skin test? What? _____ For how long? _____	☐	☐	☐
	c. Was a chest Xray performed? When? _____ Result? _____	☐	☐	☐
	d. Did you provide a copy of your chest Xray upon hire?	☐	☐	☐
2.	Have you received a tuberculin skin test in the past 12 months? If yes, what was the date of the test _____ If the TST was performed within 14 days of today's date, then another skin test may be placed. If it is less than 14 days from today's date, the team member will need to return. If TST was done at another location other than Cooper within the last 12 months, a copy must be provided to employee health for determination when another test can be completed.	☐	☐	☐
3.	Have you ever received the BCG vaccine to prevent tuberculosis? If yes, approximate date of vaccination: _____	☐	☐	☐
4.	In the past 3 weeks have you had any of the following symptoms: Cough, Sputum Production, Coughing Blood, Fever, Night Sweats, Shortness of Breath (Dyspnea), Hoarseness, Wheezing, Loss of appetite, Weight loss, Other. If yes to any, please explain: _____	☐	☐	☐
5.	Temporary or permanent residence of > 1 month in a country with a high TB rate Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe	☐	☐	☐
6.	Current or planned immunosuppression including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone > 15 mg/day for > 1 month) or other immunosuppressive medication	☐	☐	☐
7.	Close contact with someone who has had infectious TB disease since the last TB test	☐	☐	☐

Team Member: _____ **Date:** _____

If team member answers "yes" to questions 1 or 3, a TST cannot be placed.

Recommendation for follow up:

- ☐ **Refer to Occupational Health (questions 1 or 3)**
- ☐ **Follow up with their personal care provider**
- ☐ **TST/PPD not required**

Reviewed by: _____ **Date:** _____

FAX completed form to Employee Health 856.735.6496
Scan to: employeehealthnurse@cooperhealth.edu