San Diego Unified
SCHOOL DISTRICT

Human Resource Services Division
4100 Normal St.,
San Diego, CA 92103
(619) 725-7025

Adult Tuberculosis (TB) Risk Assessment Questionnaire

Must be administered by a licensed health care provider (physician, physician assistant, nurse, nurse practitioner)

Employee Name:_____ Employee ID Number:_____

Date of Birth:_____ Date of Risk Assessment:_____

History of positive TB test or TB disease ☐ Yes ☐ No

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.

If there is a "Yes" response to any of the questions #1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.	☐ Yes ☐ No
2. Close contact with someone with infectious TB disease	☐ Yes ☐ No
3. Foreign-born person (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	☐ Yes ☐ No
4. Traveler to high TB-prevalence country for more than 1 month (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	☐ Yes ☐ No
5. Current or former resident or employee of correctional facility, long-term care facility, hospital, or homeless shelter	☐ Yes ☐ No

Signature:_____ Date:_____

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Adult Tuberculosis (TB) Risk Assessment Questionnaire
Certificate of Completion

(Must be signed by the health care provider completing the risk assessment and/or examination)

The above named patient has submitted to a tuberculosis risk assessment, and if tuberculosis risk factors were identified has been examined and determined to be free of infectious tuberculosis.

_____ _____
Health Care Provider Signature **Date**

_____ _____
Health Care Provider Name **Physician License Number**

_____ _____ _____ _____
Office Address: Street **City** **State** **Zip Code**

_____ _____
Telephone **Fax**