TUBERCULOSIS RISK ASSESSMENT FOR ALL NEW FCPS EMPLOYEES

NAME: _____ **SCHOOL/BUILDING:** _____

POSITION: _____ **DATE:** _____

Code of Virginia 22.1-300 recommends that tuberculosis (TB) skin testing be performed on all individuals who may be at increased risk of TB. Please complete the following R.A.H.D. Risk Assessment form, OR provide documentation from a licensed physician, nurse practitioner, physician assistant or registered nurse of a negative TB test within the last 3 months or documentation of adequate treatment with no current symptoms.

1. Was the employee born in a country outside of the United States?
   ____ No ____ Yes What country? _____
2. Has the employee spent three or more consecutive months in a foreign country in the last five years?
   ____ No ____ Yes What country? _____
3. Has the employee been exposed or had contact with a person with active TB in the last year?
   ____ No ____ Yes Whom? _____
4. Was the employee homeless/incarcerated or did he/she live in a shelter during the last two years?
   ____ No ____ Yes
5. Does the employee have any of the following: persistent cough, coughed up blood, fever for more than one week, unexplained weight loss or HIV infection?
   _____ No ____ Yes
6. Is the employee currently taking oral steroid medications (other than inhalers), or cancer treating drugs?
   ____ No ____ Yes
7. Has the employee ever had a positive TB skin test or taken any treatment for TB disease or a positive TB test?
   ____ No ____ Yes If yes please give results and dates: _____
8. Does the employee have any of the following medical conditions?

a.	Diabetes	No	Yes	e.	Congenital or Acquired Immunodeficiency	No	Yes
b.	Malnutrition	No	Yes	f.	Siliocis	No	Yes
c.	Cancer	No	Yes	g.	Gastrectomy	No	Yes
d.	Chronic Renal Failure	No	Yes				

Medical review completed by: _____ **Date :** _____
(school nurse signature)

INSTRUCTIONS FOR THE HEALTH CARE PROVIDER: Please complete the following when the above risk assessment contains positive (yes) answers.

Date: _____

Test for TB infection: No: _____ Yes: _____
TST Reading in millimeters: _____
IGRA Result: _____
CXR Provided: No____ Yes____ Results: _____
Treatment provided: _____

Name of Health Care Provider: _____
Address: _____
Telephone: _____
Signature: _____

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