PAYMENT METHOD				TB Test
Cash	Credit	Check	Other	Screening Letter

West Virginia Department of Health and Human Resources - Division of Tuberculosis Elimination

TB Risk Assessment

Patient name: _____ **Birth date:** _____ **Today's Date:** _____
Address: _____ **City:**_____ **State:**_____ **Zip Code:**_____
Age: _____ **Gender:** _____ **Phone Number:** _____ **Alternate Phone Number:** _____

SYMPTOMS: **Does the patient have any of the following symptoms?** *(If you mark yes to any of following symptom questions please report the findings immediately to the WV Division of TB Elimination)*	**YES**	**NO**
Cough for more than 2-3 weeks		
Hemoptysis (Coughing up blood)		
Fever		
Weight loss of more than 10 lbs. for no known reason		
Loss of appetite		
Night sweats		
Weakness or extreme fatigue		

RISK FACTORS: **Does the patient have any of the following risk factors?** *(If you mark yes to any of the following risk factor questions, the patient is qualified for state funded testing)*	**YES**	**NO**
Recent contact to someone with active TB		
Born in a country other than the U.S. If yes, what country? _____		
Visited another country and stayed for 2 months or more If yes, what country? _____		
Lived in another country If yes, what country? _____		
Ever lived or worked in a prison, jail or homeless shelter		
Ever worked in a healthcare facility (including long-term care) outside of West Virginia If yes, where? _____		
Ever injected drugs not prescribed by a doctor		
Currently or ever reported having any of the following medical conditions: *(please check all that apply)* __ Diabetes __ Stomach or intestinal surgery __ HIV __ Kidney disease __ Chronic lung disease __ Colitis __ Cancer __ Rheumatoid arthritis		
Currently taking or planning to take any medication that their doctor has said could weaken their immune system or increase their risk for infection *(Examples: chemotherapy, some rheumatoid arthritis medications, organ anti-rejection drugs, some medication to treat skin disorders, etc.)*		

Patient name: _____

TB HISTORY: **Has the patient ever had any of the following?**	**YES**	**NO**
Ever had a TB skin test: If yes: When _____ Where _____ Result _____		
Ever had a TB blood test: If yes: When _____ Where _____ Result _____		
Taken the BCG vaccine *(If you mark yes to this question the patient should only receive a TB blood test, DO NOT use PPD for testing)*		
Been treated with BCG for cancer *(If you mark yes to this question the patient should only receive a TB blood test, DO NOT use PPD for testing)*		
Ever taken medication for TB in the past		
Ever been diagnosed with TB in the past		

REASON FOR TESTING: **What prompted testing today?**	**YES**	**NO**
Employer requirement		
Educational institution requirement		
Doctor requires testing prior to starting a medication		
Other (please specify):		

FOR LHD OFFICE USE:

NURSE SIGNATURE: _____ DATE GIVEN: _____ DATE READ: _____

POSITIVE: _____

NEGATIVE: _____

_____ State TST _____ State IGRA _____ Private TST _____ Private IGRA

_____ CXR _____ Diagnostic Clinic _____ Sputum X 3

_____ Letter Given _____ No Follow-Up Needed

_____ Screening Letter (testing not indicated at this time)