BEAVER COLLEGE OF
Health Sciences
APPALACHIAN STATE UNIVERSITY

Department of Nursing
Tuberculosis Risk Assessment
For individuals with a history of a positive TB test. This form should be completed and submitted to the compliance system as directed.

NAME (printed):_____ **DATE:** _____

Please answer the following questions and provide additional information for any YES answers.

1. Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe? YES NO
2. Have you traveled outside of the USA and lived for more than one month in Africa, Asia, Central America, South America, or Eastern Europe? YES NO
   Date and duration of last travel to these countries:_____
3. Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medications (e.g. Prednisone, Remicade), leukemia, lymphoma cancer or the head or neck, gastrectomy or jejunal bypass, end stage renal disease (on dialysis), or silicosis? YES NO
   Date of onset of any of the above conditions:_____
4. Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in a jail or prison, worked or resided in a homeless shelter, or worked as a healthcare worker in direct contact with patients? YES NO
   Date of use of any of the above conditions:_____
5. Have you experienced any of the following symptoms in the past year?

Symptoms	YES	NO	Symptoms	YES	NO
Fatigue			Night sweats		
Weight loss			Low grade fever		
Loss of appetite			Chest pain		
Weakness			Bloody sputum		
Persistent cough**			Prolonged period of "just not feeling well"		

Have you followed up with your health care provider regarding any categories with "yes" answers? YES NO

Answers of "Yes" should be discussed with the ASU Nursing Director of Compliance and Student Support

Date of last CXR (or not applicable (n/a)):_____
Radiologist Report submitted to ASU Nursing Program: YES NO
Date completed medication for active or latent tuberculosis (or not applicable (n/a)):_____

This information will be evaluated and you may be required to have a statement of clearance to participate in clinical from a healthcare provider of your choice.

The above information is accurate to the best of my knowledge.

Student signature:_____ Date:_____

Reviewed by:_____ Date:_____

Reviewer Comments:_____

_____

_____

Reviewer Signature:_____