



APPALACHIAN STATE UNIVERSITY

BEAVER COLLEGE OF HEALTH SCIENCES

Nursing

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.

- Were you born outside the USA in one of the following parts of the world: YES NO
Africa, Asia, Central America, South America, or Eastern Europe?
- Have you traveled outside of the USA and lived for more than one month YES NO
in Africa, Asia, Central America, South America, or Eastern Europe?
Date and duration of last travel to these countries: _____
- Do you have a compromised immune system such as from any of the following YES NO
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?
Date of onset of any of the above conditions: _____
- Have you ever done one of the following: used crack cocaine, injected illegal drugs,
YES NO 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?
Date of use of any of the above conditions: _____
- 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: _____