HEALTH CARE WORKER TUBERCULOSIS (TB) RISK ASSESSMENT TOOL

For use of this from see, MEDCOM Reg 40-64, the proponent agency is MCPO-SA

Health Care Worker Tuberculosis (TB) Risk Assessment Tool		**REVIEWER INSTRUCTION**
1. Do you have any of the following TB symptoms: cough >2 Weeks, fever >2 weeks, drenching night sweats, or unexplained weight loss?	☐ Yes ☐ No	
If "YES" ⟶ STOP. **If "NO" ⟶ Go to question #2**		**If "YES" then refer <u>immediately</u> to provider for evaluation of TB disease.**
2. Do you work in an emergency room, inpatient hospital setting, primary care clinic, mycobacteriology laboratory, or other health setting where TB patients are evaluated or treated.	☐ Yes ☐ No	
If "NO" ⟶ STOP. **If "YES" ⟶ Go to question #3**		**If "NO" then do not test.**
3. Do you have written documentation of a prior positive TB test, prior diagnosis of TB, or prior treatment for TB?	☐ Yes ☐ No	
If "YES" ⟶ STOP. **If "NO" ⟶ Go to question #4**		**If "YES" then do NOT test.**
4. Is this your first TB evaluation at this health care facility?	☐ Yes ☐ No	
If "YES" ⟶ STOP. **If "NO" ⟶ Go to question #5**		**If "YES" then perform two-step TB skin testing.**
5. Since your last TB risk assessment, did you have face-to-face contact with someone who was sick with tuberculosis (TB)? If yes, nature of exposure: Household – Co-worker – Family – Other _____ Dates of exposure _____	☐ Yes ☐ No	Indicate the Health Care Facility's current TB risk Classification: ☐ Low Risk ☐ Medium Risk ☐ Potential ongoing transmission
Reviewer comments		**If "YES" then test.** **If "NO" then test only if at a medium or high risk facility**

PATIENT'S IDENTIFICATION (For typed or written entries give: Name-last-first-middle; DOB; SSN; date; hospital or medical facility)	**REVIEWER NAME**	**REVIEWER SIGNATURE**