Latent Tuberculosis Infection: A Guide for Primary Health Care Providers

Persons with any of the following risk factors should be tested for TB infection unless there is written documentation of a previous positive TST or IGRA result.

Risk Factor	Yes	No
• Recent close or prolonged contact with someone with infectious TB disease		
• Foreign-born person from or recent traveler to high-prevalence area for more than one month		
• Chest radiographs with fibrotic changes suggesting inactive or past TB		
• Organ transplant recipient		
• Immunosuppression secondary to use of prednisone (equivalent of 2:15 mg/day for 2:1 month) or other medication such as TNF-a antagonists		
• Injection drug user		
• Resident or employee of high-risk congregate setting (e.g., prison, long term care facility, hospital, homeless shelter)		
• Medical conditions associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer of head or neck, Hodgkin's disease, leukemia, and end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (10% or more below ideal for given population]) • Signs and symptoms of TB		
• Persistent cough lasting 3 or more weeks AND one of more of the following symptoms: coughing up blood, fever, night sweats, unexplained weight loss, excessive fatigue		

Adapted from form developed by Minnesota Department of Health TB Prevention and Control Program

Tuberculosis Risk Assessment Questionnaire

To satisfy Wisconsin Administrative Code § HFS 145.08
health examinations or tuberculosis screening requirements
(To be performed by a *physician, physician assistant, nurse practitioner or registered nurse)*

CERTIFICATE OF COMPLETION

To be signed by the licensed health care provider completing the risk assessment *and/or examination*

Name: _____ Date of Risk Assessment: _____

Date of Birth: _____

The above-named individual has submitted a *tuberculosis risk assessment. The person does not have risk factors, or if tuberculosis risk factors were identified, he/she has been examined and determined to be free of infectious tuberculosis.*

_____ _____
SIGNATURE - Health Care Provider Date Signed

_____ _____
Print Health Care Provider Name Title

_____
Office Address: Street City State Zip Code

_____ _____
Telephone Fax