SFASU DeWitt School of Nursing
Annual Integrated Tuberculosis (TB) Screening and Risk Assessment Form (**TB Form**)

Name: _____ Date:_____
PLEASE CIRCLE YOUR RESPONSE

1. Since your last TB lab test or screening, have you spent more than 30 days in a country with an elevated TB rate?
   This includes all countries except those in Western & Northern Europe, Canada, Australia, and New Zealand.

   YES / NO

2. Have you had close contact with anyone who had infectious TB since your last TB test?

   YES / NO

3. Do you currently have any of the following symptoms?
   unexplained fever, cough, or fatigue for more than 3 weeks
   bloody sputum
   unintended weight loss >10 pounds

   YES / NO

4. Since your last SON screening or TB test, have you been diagnosed with latent TB infection *or* had a positive skin/blood test for TB?

   YES / NO

5. Do you have a weakened immune system for any reason?
   Examples include from organ transplant, recent chemotherapy, HIV infection, treatment with steroids for more than 1 month, or immune-suppressing medications not regulated/tested by a healthcare provider? (If you are not sure, ask your provider)

   YES / NO

_____ _____
Signature Date