Assessment for High Risk Tuberculosis (TB) Categories
Department of Human Services

Name of client: _____ Date of Birth: ____/____/____

High Risk TB Category	Client Response
1. Have you had contact with another individual with infectious TB?	☐ No ☐ Yes
2. Do you have any of the following symptoms suggestive of TB disease? ▪ Cough for ≥3 weeks duration ▪ Coughing up blood ▪ Fever ▪ Night sweats ▪ Unexplained weight loss ▪ Unusual weakness or fatigue	☐ No ☐ Yes
3. Are you a newly arrived immigrant who was referred automatically through the federal immigration system?	☐ No ☐ Yes
4. Are you infected with the human immunodeficiency virus (HIV)?	☐ No ☐ Yes
5. Are you immune-compromised due to disease or medical treatment?	☐ No ☐ Yes

Based on the responses to the questions above, I have determined that this client is not in any of the high risk TB categories identified by the Department of Human Services and I do not recommend this client complete a chest x-ray evaluation.

_____ _____/_____/_____

Signature or Stamp of Practitioner Date

_____

Printed Name of Practitioner