UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA – EMPLOYEE HEALTH SERVICES

TB Risk Assessment and Symptom Review for UMC Employees

Employee's Name (Last, First, MI):______________________________

PRNR number:______________________ Department / Unit:______________________________

TB Test History:

1. Have you ever had a positive TB Skin Test result? .... ❑ Yes ❑ No
   a. *If Yes above, please specify when*:______________________________
2. Have you ever had a positive TB Blood Test (Quantiferon or T-spot) result?........................... ❑ Yes ❑ No
   a. *If Yes above, please specify when*:______________________________
3. Do you have an *allergic reaction* (not related to the BCG vaccine) to a TB Skin Test? .... ❑ Yes ❑ No

TB Risk Assessment:

1. What is your country of birth? ❑ United States ❑ Other (Specify):______________________________
2. If not born in the U.S., when did you arrive? ❑ < 5 yrs. ago ❑ 5 – 10 yrs. ago ❑ 10 – 20 yrs. ago ❑ > 20 yrs.
3. Have you ever lived or traveled outside of the U.S. for more than one month (consecutively)? ❑ Yes ❑ No
   a. *If Yes above, please specify where and the length of time*:______________________________
4. Have you been in close contact with a person sick with TB? ❑ Yes ❑ No
5. Have you ever been treated for active TB? ❑ Yes ❑ No
   a. *If Yes above, please specify the country/state where you received treatment*:______________________________
   b. *When and how long were you treated?*______________________________
6. Have you ever been *treated* or *counseled* for latent TB (a positive TB test with a negative chest x-ray)? ❑ Yes ❑ No
   a. *If Yes to treatment, please specify the country/state where you received treatment*:______________________________
   b. *How long were you treated with medication?*______________________________
   c. *If yes to being counseled, please specify when and by whom*:______________________________
7. Do any of the below conditions/diseases apply to you? (Select all that apply)

   ❑ Hodgkin's Disease or Leukemia ❑ Hepatitis or Liver problems ❑ Thyroid Disease

   ❑ Intestinal Bypass or Gastrectomy ❑ Immune System Disorders ❑ Underweight

   ❑ Chronic kidney failure or dialysis ❑ Abnormal Chest X-Ray ❑ HIV or AIDS

   ❑ Silicosis or other lung disease ❑ Cancer of head or neck ❑ Diabetes

   ❑ Organ transplant recipient ❑ Rheumatoid Arthritis ❑ Not Applicable
8. Have any of the below situations currently or ever applied to you? (Select all that apply)

   ❑ Previously worked in the **healthcare field** ❑ History of smoking or vaping ❑ Homeless

   ❑ An inmate or worked in a jail or prison ❑ Currently smoke or vape ❑ Illicit drug use

   ❑ Lived or worked in a homeless shelter ❑ Not Applicable
9. Are you currently taking any of these medications? (Select all that apply)

   ❑ Steroids for more than 2 weeks ❑ Immunosuppressant's for more than 2 weeks ❑ Not Applicable

   ❑ Any TNF Alfa inhibitor medications: Enbrel, Erelzi (etanercept), Remicade, Ixifi, Inflectra, Avsola, Renflexis (infliximab), Simponi, Simponi Aria (golimumab), Cimzia (certolizumab), Amjevita, Humira, Cyltezo (adalimumab)

Signs & Symptoms of Active TB:

If you have ever tested positive to the TB skin or blood test, you need to be aware of the signs and symptoms of active TB (listed below).

▶ Do you CURRENTLY have any of the following symptoms?

a. Persistent cough (> 3 weeks) ...... ❑ Yes ❑ No
b. Coughing up blood....................... ❑ Yes ❑ No
c. Unexplained weight loss .... ❑ Yes ❑ No
d. Night sweats .... ❑ Yes ❑ No
e. Fatigue.. ❑ Yes ❑ No
f. Fever / chills .... ❑ Yes ❑ No

Acknowledgement & Agreement:

If I develop a persistent cough (for more than 3 weeks) and an unexplained gradual weight loss at any time, I will contact Employee Health Services immediately at 702-207-8292, ext. 2.

By signing below, I acknowledge that I have read and understand the above information. I also agree to notify Employee Health Services immediately if I have or develop any of the above symptoms.

▶ Based on my responses above, my CURRENT status is:

❑ I HAVE one or more of the above symptoms and have notified Employee Health Services.

❑ I DO NOT currently have any of the above symptoms associated with Tuberculosis.

Time:______________ Date:______________ Healthcare Worker's Signature:____

***To be completed by Employee Health / Infection Control*:**

Review Notes:

Reviewed by:

Time:______________ Date:______________ EHS Staff Member's Signature:____