Southern New Hampshire Services, Inc. – Early Head Start/Head Start/Child Care

Annual TB Risk Assessment Questionnaire

These questions are to monitor symptoms that might indicate TB disease.

You are no longer required to have a skin test for Tuberculosis (TB). Instead you are required to complete this questionnaire annually. A Tuberculin test is required for high risk individuals only. If you have questions about who may be at high risk you may contact the TB program for info. at 1-800-852-3345, ext. 4469 in NH, or outside NH at 603-271-4469

Have you had any of the following symptoms during the last year, *unexplained* and *lasting longer than 2 weeks*?	**YES**	**NO**
Fatigue		
Unintentional weight loss		
Loss of appetite		
Persistent low grade fever		
Night sweats		
Chronic respiratory symptoms		
Productive cough		
Bloody sputum		
Do you smoke?		
If *yes* how many packs a day?		

*If at any point between screenings you start to experience these symptoms for a duration longer than 2 weeks, please report it to your healthcare provider.

Have you been in contact with any of the following?	**YES**	**NO**
Anyone with or suspected of having TB		
Anyone who has been in jail or prison in the past 5 years		
Anyone with HIV or AIDS		
Residents of a nursing home		
Migrant farm workers, homeless persons, or shelters		

Have you…	**YES**	**NO**
Come from a community in which TB is prevalent?		
Traveled to a foreign country in which TB is prevalent? (i.e. Asia, Middle East, Africa, Latin America)		

Staff Name (Print clearly):_____Center:_____

Staff Signature:_____Date:_____

THIS SECTION MUST BE COMPLETED BY A HEALTH CARE PROFESSIONAL

Any questionnaire with (1) or more "yes" responses must be reviewed by a health care professional.

Reviewed by:

Health professional name (printed):_____

Health professional (signature):_____Date:_____

Further Evaluation Required? (please circle) **YES** **NO**

THIS SECTION MUST BE COMPLETED BY THE INDIVIDUAL'S HEALTH CARE PROVIDER

Tuberculin skin test performed? (please circle) **YES** **NO**

Type of skin test (Mantoux recommended):_____Date of test:_____

Date of interpretation:_____Findings:_____(mm induration)

Positive Tuberculin Skin Test must be followed by a chest x-ray and referral to a NH TB Program (271-4469)

Results of chest X-Ray:_____Date of test:_____

HCP comments:_____

Signature of Health Care Provider:_____Date:_____

October 2013