

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the Healthiest State in the Nation

TB Risk Screening Form

Tuberculosis Control Program

Phone: (239) 252-6007

Fax: (239) 963-0358

TB Symptoms

Unexplained weight loss greater than 3 weeks? Yes No

Fever Greater than 3 days? Yes No

Productive cough greater than 3 weeks? Yes No

History of TB/LTBI

Have you ever been tested for TB? Yes No Unknown

If yes, what type of test? Skin Test Blood Test Unknown

When? _____

What were the results? Positive Negative Unknown Result millimeters: _____

Have you ever taken medication for TB? Yes No Unknown _____

If yes, what TB Medication(s)?

Isoniazid Rifamycin Ethambutol Pyrazinamide Unknown Other _____

When? _____ Where? _____ How many months taken? _____

Have you ever been told that you have an abnormal chest x-ray consistent with TB?

Yes No Unknown

If yes, when were you told? _____ Where? _____

Risk Factors for Exposure

Have you ever been a contact to an infectious case of TB? Yes No

If yes, when were you last around this person? _____

Were you born in a country other than the U.S.? Yes No

If yes, what country were you born in? _____

Date Arrived in U.S.? _____

Have you ever been incarcerated or worked in a jail or correctional facility? Yes No

If yes, Employee Inmate

Have you ever been a resident or worked in a long-term residential facility? Yes No

If yes, name and location of facility: _____

Have you been a resident or worked in a shelter for the homeless? Yes No

Have you been a seasonal migrant farm worker? Yes No

Have you ever worked as a healthcare worker? Yes No

Are you a healthcare worker that routinely provides direct care to patients with pulmonary symptoms?

Yes No

Have you ever worked in a lab that processes TB specimens? Yes No

Risk Factors for Progression to Disease

Have you engaged in any of the following: Client Denies all

Drinking alcohol Injecting recreational drugs Using high risk substances

Do you have any of the following medical conditions? (Check all that apply) Client Denies all

- Cancer of the head or neck or lung
- Chronic Corticosteroid Treatment
- Chronic Immunosuppressive Treatment
- End Stage Renal Disease
- Diabetes
- Gastrectomy/Ileal Bypass
- HIV Infection
- Leukemia
- Lymphoma
- More than 10% Below Ideal Body Weight
- Organ Transplant
- Silica Exposure

Referred to TB Program? Yes

If yes, Reason for referral: TB-like Symptoms Previous Positive Incomplete Treatment

Additional Comments:

Reasons for Testing (select reason if TB testing (TST/IGRA) is to be performed)

- Contact
- Suspect/Disease
- Source Case Investigation
- Refugee
- Class A, B1, B2 or B3
- Individual Targeted (I.e., healthcare worker, student)
- Project Targeted
- CHD employee
- Administrative (I.e., low risk individual; seeking employment; school)