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Care When You Need it Most

ANNUAL TUBERCULOSIS (TB) SCREENING RISK ASSESSMENT

Employee Name	Evaluation Date

All employees are required to complete this annual Tuberculosis (TB) Screening Risk Assessment in accordance with New York State Department of Health requirements. This screening is intended to identify employees who may require additional medical evaluation.

Question	YES	NO
1. Have you had a cough lasting 3 weeks or longer?	☐	☐
2. Have you had a fever?	☐	☐
3. Have you experienced night sweats?	☐	☐
4. Have you had unexplained weight loss?	☐	☐
5. Have you coughed up blood?	☐	☐
6. Have you had chest pain or shortness of breath?	☐	☐
7. Since your last TB screening, have you been exposed to anyone with active Tuberculosis?	☐	☐
8. Since your last TB screening, have you been diagnosed with Tuberculosis or Latent TB Infection (LTBI)?	☐	☐
9. Have you ever had a positive TB Skin Test (PPD) or TB Blood Test (IGRA/QuantiFERON)?	☐	☐

If YES to Question #9 only:
Date of most recent Chest X-ray (if applicable): _____
Result: ☐ Normal ☐ Abnormal

Healthcare Provider Certification
Physician/RN Name: _____
License #: _____
Signature: _____
Date: _____
Physician/RN Stamp:

Note: *Employees with a documented prior positive TB test generally do not require repeat TB testing or routine chest X-rays unless clinically indicated or following a known exposure*.