Health Care Personnel – TB Risk Assessment

Please complete this form and send to the Medical Staff Office of your primary UR Medicine facility as noted below.

For information regarding TB Screening and Testing of health care personnel, please access the CDC website: https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm

TB (Tuberculosis) Risk Assessment *(Required for all)*

1.	In the last 5 years, have you had a history of temporary or permanent residence (for > 1 month) in a country with a high TB rate (e.g., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)?	__Yes* __ No
2.	Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone > 15mg/day for > 1 month) or other immunosuppressive medication?	__Yes* __ No
3.	Within the past year, have you had any close contact with someone who has had infectious TB disease since your last TB test and/or risk assessment?	__Yes* __ No

TB (Tuberculosis) History *(If you answered "Yes" to any of the above TB Risk Assessment questions, please compete this section.)*

a)	Have you ever been exposed to TB?	__Yes* __ No
b)	Have you ever had, or do you have a TB infection or disease?	__Yes* __ No
c)	Have you ever had any prior treatment for TB infection or exposure?	__Yes* __ No
d)	Have you had a CXR (prior diagnostic testing) for TB?	__Yes* __ No
e)	Have you had a TST (tuberculin skin test) or otherwise known as PPD in the last year?	__Yes* __ No
f)	Have you had an IGRA blood test (T-spot or QuantiFERON-TB Gold) in the last year?	__Yes* __ No
g)	Have you experienced any of the following symptoms in the past year?	
	- A productive cough for more than 3 weeks?	__Yes* __ No
	- Hemoptysis (coughing up blood)?	__Yes* __ No
	- Unexplained weight loss?	__Yes* __ No
	- Fever, chills or night sweats for no known reason?	__Yes* __ No
	- Persistent shortness of breath?	__Yes* __ No
	- Unexplained fatigue?	__Yes* __ No
	- Chest pain?	__Yes* __ No

Provider Information:

Practitioner Printed Name _____ Date _____

Practitioner Signature _____

Phone (____) _____ Email _____

Submit this form: Please fax or email this completed form to the Medical Staff Office at your primary UR Medicine facility.

	Phone	Fax	Email
FF Thompson Hospital	(585) 396-6665	(585) 396-6534	FFTHMedicalStaffOffice2@URMC.Rochester.edu>
Highland Hospital	(585) 784-8822	(585) 784-8367	MedicalStaffOffice2@urmc.rochester.edu
Jones Memorial Hospital	(585) 596-4002	(585) 596-4005	Teri_Monroe@urmc.rochester.edu
Nicholas H. Noyes Memorial Hospital	(585) 335-4324	(585) 335-4333	Hiedi_Eaton@urmc.rochester.edu
St James Hospital	(607) 385-3922	(607) 385-3195	Kelly_Grillo@urmc.rochester.edu
Strong Memorial Hospital	(585) 784-8822	(585) 784-8367	MedicalStaffOffice2@urmc.rochester.edu

** If your answer is "yes" to any of the above questions, follow-up will be required. Please refer to the Medical Staff Office at your primary UR Medicine facility for further instructions.*

Revised 09/10/2021