

RVA Pediatrics, P.C.

www.rvapediatrics.com

10410 RIDGEFIELD PKWY
RICHMOND, VA 23233
OFFICE (804)754-3776
FAX (804)754-2365

7000 PATTERSON AVE
RICHMOND VA, 23226
OFFICE (804)282-9706
FAX (804) 288-8513

14400 SOMMERVILLE CT
MIDLOTHIAN, VA 23113
OFFICE (804)379-5437
FAX (804) 379-5670

Tuberculosis (TB) Risk Assessment

Child's Name: _____ DOB: _____ Acct #: _____

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?

YES ___ NO ___ If yes, name of symptoms: _____

2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?

YES ___ NO ___

3. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?

YES ___ NO ___ If yes, in what country did the child travel to: _____

4. Is the child exposed to a person who?

- Is currently in jail or who has been in jail in the past 5 years?
- Has HIV?
- Is homeless?
- Lives in a group home?
- Uses illegal drugs?
- Is a migrant farm worker?

YES ___ NO ___ If yes, name the risk factors the child is exposed to: _____

5. Does the child have any history of weakened immune system (Diabetes, Kidney Disease, Crohn's Disease, Cancer, Irritable Bowel Disease or Asplenia) and/or take medications such as chronic steroids that might weaken immune system?

YES ___ NO ___ If yes, name of disease or medications: _____

If the answer to any of these questions is YES, your child may be at risk for tuberculosis, provider will discuss further testing.

Parent's Signature: _____ Date: _____

Relationship: _____