California School Employee Tuberculosis (TB) Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading disease.
- **Do not repeat testing** unless there are **new risk factors since the last negative test**.
- **Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:**
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.
  A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____ **Date of Birth:** _____

History of Tuberculosis Disease or Infection (Check appropriate box below)
☐ **Yes** • If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.
☐ **No** (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if any of the 3 boxes below are checked
☐ **One or more sign(s) or symptom(s) of TB disease** • TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.
☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month • Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries. • Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.
☐ **Close contact** to someone with infectious TB disease during lifetime
Treat for LTBI if TB test result is positive and active TB disease is ruled out

^The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

*To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.*

First and Last Name of the person assessed and/or examined:

_____

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X_____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

Interdepartmental Recharge / Authorization For UCI SHC MEDICAL/DENTAL SERVICES

To Set Up Your Appointment
Call (949) 824-5301
Please complete form entirely. One form per client/patient.

Date: _____

Client/Patient Information

Client/Patient Name: _____

Reason For Visit: Clearance Form / TB-Test

Department Information

Department Name: Education- CalTeach Science and Math Program

Department Phone: (949) 824-5672 **Fax:** (949) 824-0694

Mail/Zot Code: 5506

Authorized by:

Chelsea Barilli
Signature

Chelsea Barilli
Print Name

General Ledger Recharge Information

Control Account / Object Code / Project Code
EI10243 / _____ / _____

Fiscal Officer: 5500 **Zot:** Lynn Wong

Notes: 1. The signature above authorizes the client/patient indicated to receive medical services at the UCI Student Health Center. Furthermore the signature above authorizes the UCI Student Health Center to recharge all services, ancillary, administrative charges/fees, and charge fee adjustments to the account/fund indicated above. 2. Recharges are processed monthly by SHC Analyst, ext.5129. 3. Recharge client/patients will not be seen without a completed authorization. Forms not completed in their entirety will result in a rescheduling of client/patient appointment. 4. A fee will be assessed for all missed appointments not cancelled in advance.