

Name of Person in Care: _____

**TUBERCULOSIS RISK ASSESSMENT FORM
FOR PERSONS IN CARE OF COMMUNITY CARE FACILITIES, 60 years and older**

Residents **60 years and older** will be assessed for symptoms of active TB and risks for developing active disease, and if symptomatic or at risk, referred for further evaluation including a chest x-ray prior to admission.

Symptoms of TB include: productive, prolonged cough (lasting more than three weeks); hemoptysis (coughing up blood); fever, weight loss, night sweats (with no other confirmed diagnosis); non-resolving pneumonia.

Risk factors for developing active TB disease include: substantial immune suppression (especially people with HIV/AIDS), and known contacts to individuals with infectious TB disease within the prior two years.

Please check one of the following boxes:

- Yes**, presence of symptoms or risk factors is applicable and documentation of further tuberculosis testing will be provided.
- No**, presence of symptoms or risk factors listed above is not applicable.
- Unknown**, cannot determine presence of above listed risk factors as history is not known.

Name of person filling out form:

(Print Name) _____

(Signature) _____

(Relationship to Person in Care) _____

To be completed by the facility:

*** Presence of symptoms or risk factors or an unknown history requires documentation of further follow-up.**

- Documentation Received

Date of Receipt: _____