GCGHD
GALLIA COUNTY GENERAL HEALTH DISTRICT
ETHAN STEPHENS, D.O.
HEALTH COMMISSIONER/MEDICAL DIRECTOR

Public Health
Prevent. Promote. Protect.
Gallia County
Health Department

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TB Risk Assessment

Name:_____ Birthdate_____

Address:_____Phone:_____

Please answer the following questions	YES	NO
Have you had temporary or permanent residence of ≥ 1 month in a country with a high TB rate? (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe)		
Current or planned Immunosuppression? (Including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication)		
Close contact with someone who has had infectious TB disease since your last TB test?		
Have you ever had a positive TB skin test?		
Is your employer requiring you to have this TB skin test? If so please list name of employer below. _____		
Is your education institution requiring you to have this TB skin test? If so please list the name of your education institution below. _____		
Are you requesting this TB skin test for a different reason? If so please list reason for requesting test below. _____		

I hereby consent to receive Tuberculin skin testing. I authorize the release of Tuberculin skin test information to other health care agencies, schools, and my place of employment at the discretion of the Health Department staff. I authorize the Health Department to place my or my child's Tuberculin skin test information in an electronic database. I also authorize the Health Department to bill for my or my child's service today. The presence of my signature certifies that I have received information on the HIPAA Privacy Notice.

_____ _____

Signature of Client/Authorized Guardian Date

CDC Centers for Disease Control and Prevention National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

For Office Use Only

Location: LFA RFA Lot Number:_____

Nurse Signature:_____ Date:_____

For Step 2

Location: LFA RFA Lot Number:_____

Nurse Signature:_____ Date:_____