INTERIM TUBERCULOSIS EXPOSURE RISK ASSESSMENT

FOR THE PATIENT *(Check the correct response)*

1. Since your last tuberculosis risk assessment, were you exposed to anyone known to have or suspected of having active tuberculosis (i.e., individuals with persistent cough, weight loss, night sweats, and/or fever)? ☐ YES ☐ NO ☐ DON'T KNOW

2. Since your last Tuberculosis Exposure Risk Assessment or Post-Deployment Health Assessment (DD Form 2796), did you have direct and prolonged contact with any individuals of the following groups: refugees or displaced persons; hospitalized patients, prisoners, or homeless shelter populations? ☐ YES ☐ NO

3. List any countries where you have traveled or deployed to since your last tuberculosis risk assessment.

4a. During this travel, did you have direct and prolonged contact with the local population? ☐ YES ☐ NO

4b. If yes, explain.

FOR THE PROVIDER

5. Tuberculosis risk assessment, based on above responses ☐ MINIMAL RISK ☐ INCREASED RISK

6. Recommend LTBI Testing ☐ YES ☐ NO

7. Provider Comments

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	