



# TB Document G: State of Hawaii TB Risk Assessment for Adults and Children

Hawaii State Department of Health  
Tuberculosis Control Program

## 1. Check for TB symptoms

- If there are significant TB symptoms, then further testing (including a chest x-ray) is required for TB clearance.
- If significant symptoms are absent, proceed to TB Risk Factor questions.

<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p><b>Does this person have significant TB symptoms?</b> Significant symptoms include <u>cough for 3 weeks or more</u>, plus at least one of the following:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Coughing up blood</td> <td style="width: 33%;"><input type="checkbox"/> Fever</td> <td style="width: 33%;"><input type="checkbox"/> Night sweats</td> </tr> <tr> <td><input type="checkbox"/> Unexplained weight loss</td> <td><input type="checkbox"/> Unusual weakness</td> <td><input type="checkbox"/> Fatigue</td> </tr> </table>	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unusual weakness	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats					
<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> Unusual weakness	<input type="checkbox"/> Fatigue					

## 2. Check for TB Risk Factors

- If any “Yes” box below is checked, then TB testing is required for TB clearance
- If all boxes below are checked “No”, then TB clearance can be issued without testing

<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p><b>Was this person born in a country with an elevated TB rate?</b> Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.</p>
<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p><b>Has this person traveled to (or lived in) a country with an elevated TB rate for four weeks or longer?</b></p>
<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p><b>At any time has this person been in contact with someone with <i>infectious TB disease</i>?</b> (Do not check “Yes” if exposed only to someone with latent TB)</p>
<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p><b>Does the individual have a health problem that affects the immune system, or is medical treatment planned that may affect the immune system?</b> <i>(Includes HIV/AIDS, organ transplant recipient, treatment with TNF-alpha antagonist, or steroid medication for a month or longer)</i></p>
<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p><b>For persons under age 16 only: Is someone in the child’s household from a country with an elevated TB rate?</b></p>

<b>Provider Name with Licensure/Degree:</b>   <b>Assessment Date:</b>	<b>Person's Name and DOB:</b>   <b>Name and Relationship of Person Providing Information (if not the above-named person):</b>
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