



Components of TB Patient Assessment

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Introduction to TB Nurse Case Management Online
Wednesdays, January 15 – February 5, 2025
Online from San Antonio, Texas

Debbie Davila, MSN, RN has the following disclosures to make:

- No conflict of interests
- No relevant financial relationships with any commercial companies pertaining to this educational activity





Components of TB Patient Assessment

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Introduction to TB Nurse Case Management Online Course

January 15 – February 7, 2025

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Objectives

- Identify components of TB Patient Assessment
 - Medical History
 - TB History
 - TB signs and symptoms
 - Co-morbidities



Purpose of the Nurse Assessment

- Identifies the needs, preferences, and abilities of a patient
- Includes an interview with and observation of a patient and considers the symptoms and signs of the condition, the patient's verbal and nonverbal communication, the patient's medical and social history, and any other information available
- Provides the scientific basis for a complete nursing care plan

<http://medical-dictionary.thefreedictionary.com/nursing+assessment>



Nurse Assessment

- Done Initially
- Updated and ongoing
 - Physically view patient
 - Appearance (i.e., thin, frail)
 - Assess symptoms
 - Clinically improving or worsening
 - Manage side effects/toxicities
 - Prevent adverse reactions
- Intervene rapidly
- Address issues immediately



UPDATE



Assessment

- **Gather Data**

- Collect medical history from all medical providers to determine onset of symptoms

- **Hospital**

- H&P, admission notes, discharge summaries, microbiology results, lab reports, radiology reports

- **Health Dept. records**

- Prior screenings
- Prior CXR
- Treatment of LTBI or TB disease

- **PCP notes**

- Prior c/o TB symptoms
 - Allergies
 - Cough

STATE OF ILLINOIS - DEPARTMENT OF CORRECTIONS

Facility: PO7

MEDICAL PROGRESS NOTES

Inmate's Name: [REDACTED] Inmate's Number: [REDACTED]

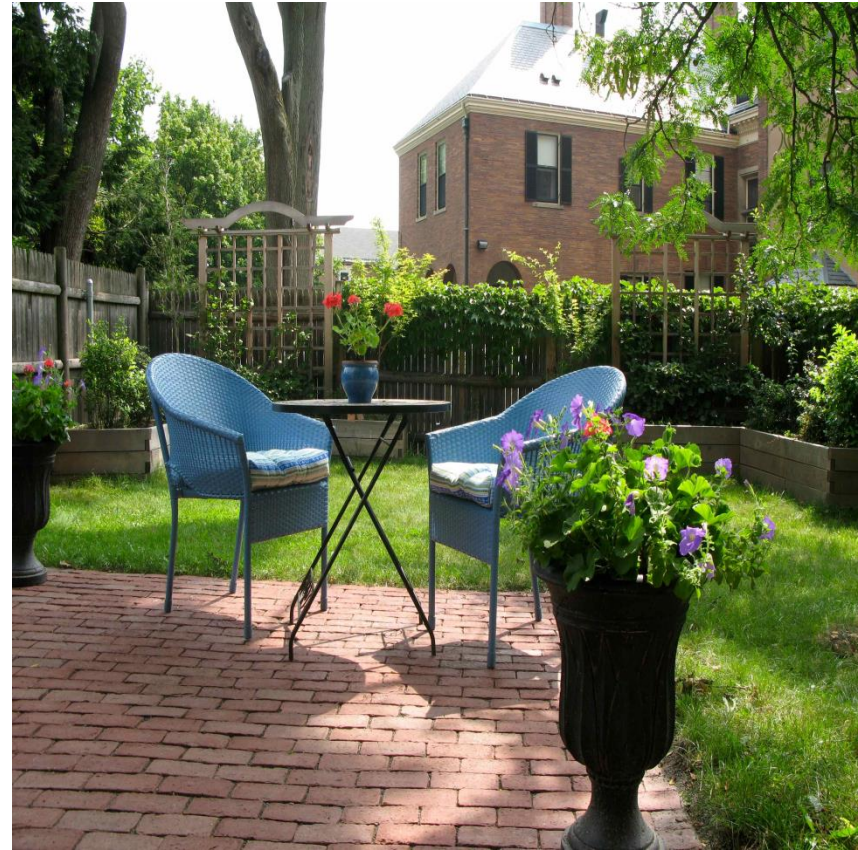
Date/Time	SOA	PLANS
4.20.12	[REDACTED]	P. O. Report to in SIC
0830	S. Cough & difficulty breathing this am - Smoke in next cell from resident during T.P.	Stat
	B. Chest: Inj. & Exp. coarse crackles	
	A. Bronchitis,	R. Almbli. use noted
		W. Coloured m.
		5/21/92 0837
5/24/12	[REDACTED]	
1440	S. Lat 5/18/12 Therapy 2.5 Just re-started on thebus	P. O. Report the phle level 5/22/12
	A. Possibly not on drug long enough	R. Almbli. use

DC 7147 R 428-0017 P-148 (Rev 08/90)

noted
5/20/12
1440

Confidentiality & Privacy

- Maintain confidentiality & privacy
- Ensure that the patient is comfortable
- If done at the clinic or home
 - Can do assessment outdoors
 - Do not have to use mask
- Build rapport



Building Rapport

- Obtaining essential information to develop a treatment plan specific to that patient
 - Medical
 - Social
- **Do Not Interrogate**
- **Do Not use judgmental tone**

Rapport
[rā-pô'r', rə-]
-noun
1. An expected amount
mutual cooperation and
understanding established
on trust between two or
more parties.

If the patient feels interrogated or judged, the patient is likely to be closed and unresponsive to questions and may disregard advice and instructions

Keep an Open Mind!!!



Nurse Assessment

Texas Department of State Health Services Tuberculosis Initial Health Risk Assessment/History

SSN	Medicaid#	DOB	Sex	Phone 1
Last	First	Middle	Phone 2	
Street Address		City	County	State Zip

ATS Classification	
<input type="checkbox"/> 0-No M. TB exposure, not infected	<input type="checkbox"/> 3-M. TB disease, clinically active
<input type="checkbox"/> 1-M. TB exposure, no evidence of infection	<input type="checkbox"/> 4-Previous M. TB disease, not clinically active
<input type="checkbox"/> 2-M. TB infection, no TB disease	<input type="checkbox"/> 5-M. TB suspect, diagnosis pending

Initial Assessment	
Primary reason evaluated for TB: <input type="checkbox"/> Contact investigation <input type="checkbox"/> Immigration medical exam <input type="checkbox"/> Health care worker <input type="checkbox"/> Employment/administrative testing <input type="checkbox"/> Targeted testing <input type="checkbox"/> TB symptoms <input type="checkbox"/> Abnormal chest radiograph (consistent with TB) <input type="checkbox"/> Incidental lab result <input type="checkbox"/> Unknown	
Date of assessment:	Assessment conducted by:
Location of the assessment: <input type="checkbox"/> Clinic <input type="checkbox"/> Patient home <input type="checkbox"/> Hospital <input type="checkbox"/> Jail/prison <input type="checkbox"/> Long term care facility <input type="checkbox"/> Other, specify other:	

Pediatric TB Patients (<15 years old)	
Country of birth for primary guardian(s):	Primary guardian relationship:
Patient lived outside US for >2 months: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Countries:

Demographics	
Country of birth:	Born in the US (or born abroad to a parent who was a U.S. citizen): <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of arrival in the US:	
Races: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic or Not Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refused
Extended race(s):	
Middle Eastern: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify country(ies):	

Foreign Birth or Travel	
Immigration status at first entry to the US: <input type="checkbox"/> Not applicable <input type="checkbox"/> Immigrant visa <input type="checkbox"/> Student visa <input type="checkbox"/> Employment visa <input type="checkbox"/> Tourist visa <input type="checkbox"/> Family/fiancé visa <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee or parolee <input type="checkbox"/> Other immigration status <input type="checkbox"/> Unknown Specify other:	
Notice of arrival of alien with TB class: <input type="checkbox"/> A <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3 Alien number:	
Binational status: <input type="checkbox"/> Contacts <input type="checkbox"/> Laboratory/radiologic testing <input type="checkbox"/> Counter Border Crosser or Transnational <input type="checkbox"/> Not Counted Border Crosser <input type="checkbox"/> Counted by Binational Program Only/Binacional	
Residence or travel in country with high prevalence of TB in last 2 years: <input type="checkbox"/> Yes <input type="checkbox"/> No	Country:
Date of travel:	Approximate length of stay/residence:
Have you traveled for 8 consecutive hours while symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Method of transportation: <input type="checkbox"/> Flight <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/> Ship/boat Specify:
Comments:	

WHAT
HOW
WHY
WHOSE
WHERE
WHICH
WHEN



Demographics

Get as much information as you can about where patient can be located

- How long at this address
- Previous address
- Alternate address
- Get emergency contact information
 - Who can be contacted to locate patient
 - Unable to locate
 - In case patient moves



Texas Department of State Health Services
Tuberculosis Initial Health Risk Assessment/History

SSN	Medicaid#	DOB	Sex	Phone 1	
Last	First	Middle	Phone 2		
Street Address		City	County	State	Zip



Demographics	
Country of birth:	Born in the US (or born abroad to a parent who was a U.S. citizen): <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of arrival in the US:	
Races: <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Refuse	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic or Not Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Refused
Extended race(s):	Middle Eastern: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify country(ies):
Foreign Birth or Travel	
Immigration status at first entry to the US: <input type="checkbox"/> Not applicable <input type="checkbox"/> Immigrant visa <input type="checkbox"/> Student visa <input type="checkbox"/> Employment visa <input type="checkbox"/> Tourist visa <input type="checkbox"/> Family/fiancé visa <input type="checkbox"/> Refugee <input type="checkbox"/> Asylee or parolee <input type="checkbox"/> Other immigration status <input type="checkbox"/> Unknown Specify other:	
Notice of arrival of alien with TB class: <input type="checkbox"/> A <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3	Alien number:
Binational status: <input type="checkbox"/> Contacts <input type="checkbox"/> Laboratory/radiologic testing <input type="checkbox"/> Counter Border Crosser or Transnational <input type="checkbox"/> Not Counted Border Crosser <input type="checkbox"/> Counted by Binational Program Only/Binacional	
Residence or travel in country with high prevalence of TB in last 2 years: <input type="checkbox"/> Yes <input type="checkbox"/> No	Country:
Date of travel:	Approximate length of stay/residence:
Have you traveled for 8 consecutive hours while symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Method of transportation: <input type="checkbox"/> Flight <input type="checkbox"/> Bus <input type="checkbox"/> Train <input type="checkbox"/> Ship/boat Specify:
Comments:	

Medical History

Date medical history collected: _____	
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Arthritis/gout: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Use of <input type="checkbox"/> Remicade <input type="checkbox"/> Humira <input type="checkbox"/> Enbrel	
Autoimmune: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Cancer: <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Other	Comments:
Specify other: _____	
Chronic malabsorption syndrome: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Chronic renal failure: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Corticosteroids (received equivalent of >15 mg/d Prednisone for >1 month): <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Diabetes mellitus: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	
Diabetes controlled: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Comments:
Controlled through: <input type="checkbox"/> Pills <input type="checkbox"/> Insulin <input type="checkbox"/> Unknown	Comments:
GI/gastroectomy or jejunioileal bypass: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Gynecological: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Heart disease/PVD: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Hypertension/CVA: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Intellectual disability/developmental delay: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Leukemia: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Liver disease/hepatitis (risk factors HepB/C: IDU, HIV+ or birth in Asia, Africa or Amazon basin): <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Lymphoma: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Mental illness(es): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Anxiety	Comments:
<input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Specify other: _____	
When (select all that apply):	
<input type="checkbox"/> Currently <input type="checkbox"/> Within past 12 months <input type="checkbox"/> Ever	
Neurological/seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Organ transplant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Post partum: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Respiratory problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Silicosis/asbestosis: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Skin disease: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
STD: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Surgeries/hospitalizations: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Thyroid: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Vision/hearing disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:
Other medical history: <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments:



TB History

- May have to contact local health department in city/county that patient lives in
 - May have previously been screened as a contact to a case
 - Contact to an MDR case
- Determine if patient previously treated for LTBI or TB disease
- How long ?
 - **6, 9, 12, 18, 24 months**
- What drugs?
- Supporting Documentation



Last		First		Middle		DOB	
Previous History of TB and TB Infection							
Recurrence or previous diagnosis of TB or TB infection: <input type="checkbox"/> TB Disease <input type="checkbox"/> TB Infection <input type="checkbox"/> No <input type="checkbox"/> Unknown							
History: <input type="checkbox"/> Documented <input type="checkbox"/> Self report				Previous TB occurred in US: <input type="checkbox"/> Yes <input type="checkbox"/> No			
State/Country:				State case number (if reported in Texas after 1993):			
Most recent year of previous diagnosis:				More than one previous episode: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			
Start date previous TB treatment:				Start date previous TB infection treatment:			
Stop date previous TB treatment:				Stop date previous TB infection treatment:			
Previous TB drug regimen/Dosage (mg):				Previous TB infection drug regimen/Dosage (mg):			
Previous TB treatment documented: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				Previous TB infection treatment documented: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Previous TB treatment considered complete: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				Previous TB infection treatment considered complete: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Previous positive IGRA: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> QFT <input type="checkbox"/> T-SPOT Date:				Date of chest X-Ray: Result: <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> Unknown			
Previous positive TST: <input type="checkbox"/> Yes <input type="checkbox"/> No Induration: mm Date:				Abnormal result: <input type="checkbox"/> Cavitory <input type="checkbox"/> Non-cavitory			
Comments:							
History of TB Exposure							
Known exposure to active TB case: <input type="checkbox"/> Yes <input type="checkbox"/> No				How many years: <input type="checkbox"/> Greater than 3 years <input type="checkbox"/> 3 years or less			
Date:				Relationship to patient:			
Comments:							

Radiology

- Gather all radiology reports
 - X-rays, CT-Scans, Pet Scans, MRI's
- Reports show cavities? Infiltrates? Scarring?
- Films for comparison?



TB Symptoms

Symptoms			
TB symptoms screening performed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient is symptomatic: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Date of TB symptoms assessment: _____			
Symptom	Onset date	Symptom	Onset date
Chest pain: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____	Weight loss (>10%): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____
Shortness of breath: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____	Frequent urination, bloody urine or flank pain: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____
Fever/chills: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____	Headache, decreased level of consciousness or neck stiffness: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____
Night sweats: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____	Swelling of joint/vertebra: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____
Cough (persistent x3 weeks): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____	Enlarged cervical lymph nodes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____
Productive cough: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____	Swelling of lymph nodes: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____
Hemoptysis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____	Eye pain or blurry vision: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____
Fatigue: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____	Pain swelling in other locations: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____
Loss of appetite: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	_____	Other: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable Specify other: _____	_____
Source of symptom information: <input type="checkbox"/> Patient interview <input type="checkbox"/> Relative/friend <input type="checkbox"/> Medical record <input type="checkbox"/> Other Specify other: _____		Respiratory isolation indicated: <input type="checkbox"/> Yes <input type="checkbox"/> No Date placed in respiratory isolation: _____	
Notes: _____			



Gathering Information

- Gather chronological history of presenting signs and symptoms
 - Most patients will have difficulty remembering when symptoms began
- Refer back to important dates and times
 - Christmas, Thanksgiving, Birthday, Birth of a Baby

These cues may prompt patient memory and give us more accurate dates as when symptoms began

- *Important in determining infectious period and conducting contact investigations*



Social History

Risk and Social History	
Population Risks	Medical Risks
Contact to infectious TB patient (2 years or less): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cancer: <input type="checkbox"/> Head <input type="checkbox"/> Lung <input type="checkbox"/> Neck
Contact to MDR-TB case (2 years or less): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Chronic renal failure or on hemodialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Inner-city resident: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If patient has diabetes, was nutrition education provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
Low income: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	End-stage renal disease: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
History of homelessness (current or previous): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	History of untreated or inadequately treated active TB, including fibrotic changes on X-Ray consistent with previous TB: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Current resident of homeless shelter: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Immunosuppression (not HIV/AIDS): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Homeless within past year: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Incomplete TB infection therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
History of incarceration (current or previous): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Missed contact (2 years or less): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Type of correctional facility: <input type="checkbox"/> Federal prison <input type="checkbox"/> Juvenile correctional facility <input type="checkbox"/> Local jail (city or county) <input type="checkbox"/> State prison <input type="checkbox"/> Other correctional facility <input type="checkbox"/> Unknown Specify other: _____	Recently infected with M. tuberculosis (within the past 2 years): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Is the detainee in ICE custody? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Skin test conversion - increase of 10mm or more within 2 years: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Under custody of immigration and customs enforcement: <input type="checkbox"/> Yes <input type="checkbox"/> No	TNF-alpha antagonist therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Incarceration date at diagnosis: _____	Other medical risks: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Specify other: _____
Current resident of long-term care facility: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Testing required by employer or school program: <input type="checkbox"/> Yes <input type="checkbox"/> No
Resident of other congregate setting at diagnosis: <input type="checkbox"/> Colonia <input type="checkbox"/> Displaced citizen <input type="checkbox"/> School dorm <input type="checkbox"/> Unaccompanied alien child/minor (UAC) <input type="checkbox"/> Homeless Shelter <input type="checkbox"/> Other Specify other: _____	Injecting drug use within past year: <input type="checkbox"/> No <input type="checkbox"/> Injected drugs <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Other illicit drug Specify other: _____ Patient was provided additional resources: <input type="checkbox"/> Yes <input type="checkbox"/> No
Employee of high risk congregate setting or institution: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Non-injecting drug use within past year: <input type="checkbox"/> No <input type="checkbox"/> Marijuana <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Crack <input type="checkbox"/> Methamphetamines <input type="checkbox"/> Other illicit drug Specify other: _____ Patient was provided additional resources: <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary occupation in the past year: <input type="checkbox"/> Correctional facility employee <input type="checkbox"/> Health care worker <input type="checkbox"/> Migrant/seasonal worker <input type="checkbox"/> Not seeking employment <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Other <input type="checkbox"/> Unknown Specify other: _____	Tobacco use: <input type="checkbox"/> Yes <input type="checkbox"/> No Packs per day: _____ Years of use: _____ Patient was provided additional resources: <input type="checkbox"/> Yes <input type="checkbox"/> No
Correctional facility employee type: <input type="checkbox"/> Inmate <input type="checkbox"/> Volunteer	Alcohol use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown In the last 30 days, how many days did the patient consume more than 4 drinks? <input type="checkbox"/> 0-4 days <input type="checkbox"/> 5 days or more <input type="checkbox"/> Unknown Patient was provided additional resources: <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason not seeking employment: <input type="checkbox"/> Child <input type="checkbox"/> Disabled <input type="checkbox"/> Homemaker <input type="checkbox"/> Institutionalized <input type="checkbox"/> Student	



Summary

- The TB Case Manager should conduct a face-to-face interview with the patient in efforts to develop a plan of care
- Assessment is ongoing and dynamic and should be continuous throughout the course of the patient's treatment
- The purpose for assessment to development of a treatment plan with a goal for successful completion of treatment





It's time to invest in nurses and healthcare workers

Nurses and health workers play a critical role in tuberculosis prevention and care. Enabling them to work to their full potential improves healthcare for all.

