



TB Nurse Assessment

Maricela Zambrano, RN

September 23, 2026

TB Nurse Case Management • September 23 – 25, 2026 • Edinburg, Texas



Maricela Zambrano, RN

Has the following disclosures to make:

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



TB Nurse Assessment

TB Nurse Case Manager Training

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Objectives

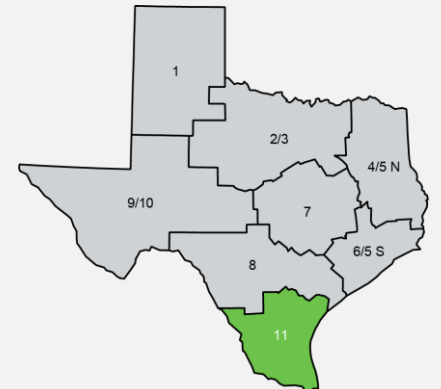
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Explain the Components of the TB Nurse Assessment

- Gathering and collecting data
- Medical history
- Psychosocial history
- TB history
- Environmental assessment



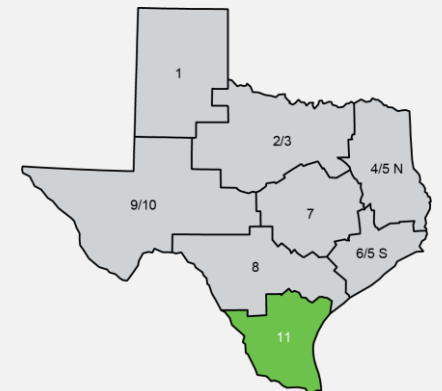
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Identifies the needs, preferences, and abilities of a patient

- 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



Gathering and Collection of Data

Collect medical history from all medical providers

- Hospitals
- Health Department records
- Primary Physician
- Specialists



Maintain Confidentiality & Privacy

Hospital Collaboration

- Admission Notes
- History and Physical
- Discharge summary
- MARS
- Microbiology reports: AFB and MTB PCR
- Radiology reports: chest x-ray, CT scans and/or Ultrasounds, MRI if applicable



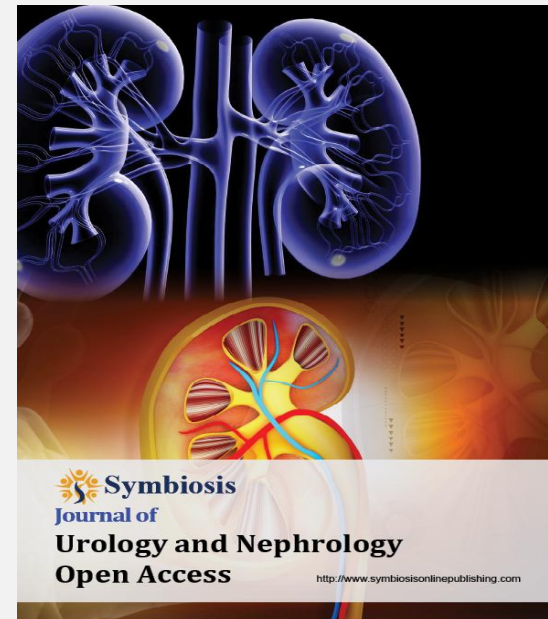
Health Department Collaboration

- Prior Screenings
- Prior radiology results
- Prior treatment of TB or LTBI



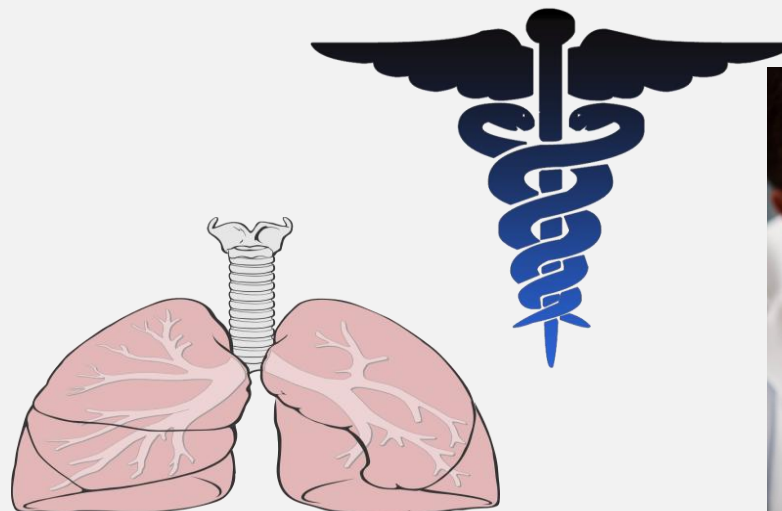
Primary Care and/or Specialists

- Visit notes
- Labs
- Radiology reports



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Building Rapport

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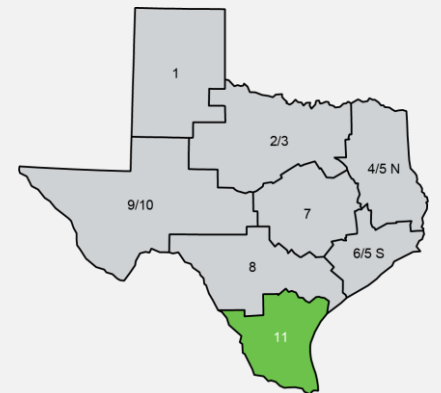
Rapport

[rā-pôr', rə-]

-noun

1. An expected amount mutual cooperation and understanding established on trust between two or more parties.

- ✓ Listen more than you talk – silence is powerful!
- ✓ Use open-ended questions – not yes/no questions.
- ✓ Watch your body language – sit down, make eye contact, and nod.
- ✓ Stay calm and patient – even if the patient is angry or upset.
- ✓ Never argue or challenge the patient – stay supportive.

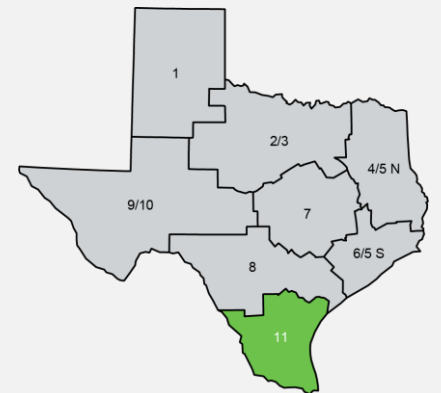


Building Rapport

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- Maintain Confidentiality and Privacy
- Ensure the patient feels comfortable
- Obtain written authorization to share patient information
- Verify patient identification and privacy when on phone calls



Consent to Release Confidential Medical Information

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TEXAS
Department of
State Health Services
TX DSHS Public Health Nursing

Consent to Release Confidential Medical Information

Instructions on reverse

Name: _____
(Name of client)

Address: _____
(Street Number, Post Office Box, Route Number) (City) (State) (Zip)

I authorize the following individual:

(Individual, Physician, Hospital, Clinic, Attorney, Counselor, School, etc.)

(Street Number, Post Office Box, Route Number) (City) (State) (Zip)

to release the following specific confidential information:

☐ Yes ☐ No

Developmental Information: (Indicate specific information below)

☐ Yes ☐ No

Educational Plan: (Indicate specific information below)

☐ Yes ☐ No

Financial Information: (Indicate specific information below)

☐ Yes ☐ No

Legal Information: (Indicate specific information below)

☐ Yes ☐ No

Medical Information: (Indicate specific information below)

☐ Yes ☐ No

HIV-Related Information: (Indicate specific information below)

☐ Yes ☐ No

Psychological Reports: (Indicate specific information below)

☐ Yes ☐ No

Social History: (Indicate specific information below)

☐ Yes ☐ No

Other: (Indicate specific information below)

To the following individuals:

(Name or Position of Individual/Organization, if any, represented)

(Street Number, Post Office Box, Route Number) (City) (State) (Zip)

The information released may be used by the individual, or the organization represented by the individual for the following purpose(s): (list below)

I understand that: 1) I may revoke this authorization in writing by contacting the DSHS office or program that obtained the authorization; 2) this authorization will not affect treatment, payment, enrollment, or eligibility for benefits; and 3) information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law.

EXPIRATION DATE: This authorization will expire on: (date or event) _____
(if no date or event is stated, expiration is one year from signature date)

This form ☐ was read by me ☐ was read to me and I understand its meaning. All the blanks were filled in before the form was signed by me.

(signature) (Signature Date)

(Print/Type Name of Person Authorized to Consent to Release of Information)

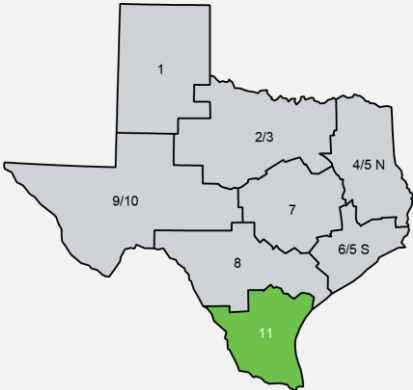
(Signature of Authorized Person)

(Address) (Telephone) (Date)

PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

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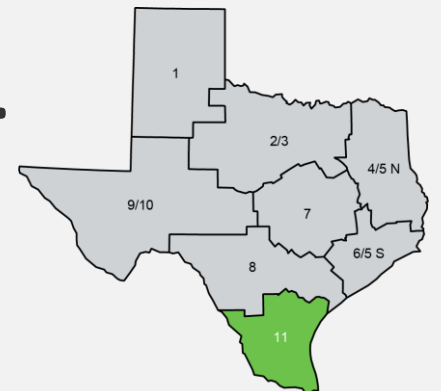
Speaking with a patient

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- Avoid using medical jargon
- Speak to them in their own language or use an interpreter line
- Explain some topics may be sensitive but provide rational
- Cue patient's memory by asking specifics. (Categories, events)
- Allow time and answer questions.



TB Initial Health Risk Assessment/History

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Demographics

- Current Address
- Previous address
- Alternate Address
- Emergency Contact



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

SSN	Medicaid#	DOB	Sex at Birth	Phone 1
Last	First	Middle	Phone 2	
Street Address	City	County	State	Zip
Additional Patient Information				
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ UNK				
Race: ☐ American Indian or Alaska Native ☐ Asian, specify: ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander, specify: ☐ White ☐ Other race, specify: ☐ UNK				
ATS Classification				
☐ 0-No M. TB exposure, not infected		☐ 3-M. TB disease, clinically active		
☐ 1-M. TB exposure, no evidence of infection		☐ 4-Previous M. TB disease, not clinically active		
☐ 2-M. TB infection, no TB disease		☐ 5-M. TB suspect, diagnosis pending		
Initial Report and Assessment				
How was the patient first reported to the health department: ☐ Contact investigation ☐ Electronic disease notification (EDN) referral ☐ Electronic lab report (ELR) ☐ Genotyping ☐ Hospital referral ☐ Interjurisdictional notification (IJN) ☐ Private Provider referral ☐ Targeted testing ☐ Vital statistics ☐ Walk-in ☐ Other, specify:				
Initial reason evaluated for TB: ☐ Contact investigation ☐ Screening ☐ TB symptoms ☐ Other ☐ UNK				
Date of initial assessment:		Assessment conducted by:		
Location of the assessment: ☐ Health department ☐ Correctional facility ☐ Hospital ☐ Long term care facility ☐ Private outpatient clinic ☐ Other, specify (e.g., patient home):				
Vital Status and Country of Origin				
Status at diagnosis (confirmed TB cases only): ☐ Alive ☐ Dead				
Country of birth:		Eligible for U.S. Citizenship/Nationality at Birth (regardless of county of birth): ☐ Yes ☐ No ☐ UNK		
If not U.S., date of first U.S. arrival:				
Country of birth for primary guardian(s) (for pediatric TB patients <15 years old cases only):				
Guardian 1:		Guardian 2: Relationship of primary guardian:		
Country of usual residence:				
If not U.S. reporting area, has been in the U.S. for ≥90 days (inclusive of report date)? ☐ Yes ☐ No ☐ UNK				

TB History

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Previous History of TB or LTBI

- Previous treatment
- Previous positive TB test
- Previous radiology
- Previous Exposure



Last	First	Middle	DOB
Previous History of TB and Latent TB Infection (LTBI)			
Has the patient been previously diagnosed with TB disease or LTBI: ☐ TB Disease ☐ LTBI ☐ No ☐ UNK			
History: ☐ Documented ☐ Self-reported		Previous TB occurred in U.S.: ☐ Yes ☐ No	
State/Country of previous TB disease or TB infection:		Previous state case number (if reported in Texas after 1993):	
Date of previous diagnosis:		More than one previous episode: ☐ Yes ☐ No ☐ UNK	
Start date previous TB treatment:		Start date previous LTBI treatment:	
Stop date previous TB treatment:		Stop date previous LTBI treatment:	
Previous TB drug regimen/Dosage (mg):		Previous LTBI drug regimen/Dosage (mg):	
Previous TB treatment documented: ☐ Yes ☐ No ☐ UNK		Previous LTBI treatment documented: ☐ Yes ☐ No ☐ UNK	
Completed treatment?: ☐ Yes ☐ No ☐ UNK		Completed LTBI treatment?: ☐ Yes ☐ No ☐ UNK	
Previous positive IGRA: ☐ Yes ☐ No ☐ UNK ☐ QFT ☐ T-SPOT		Previous imaging type: ☐ Plain CXR ☐ CT Scan ☐ MRI ☐ PET ☐ Other	
Date Collected: Date Reported:		Previous imaging date:	
Previous positive TST: ☐ Yes ☐ No ☐ UNK		Result: ☐ Consistent with TB ☐ Not consistent with TB	
Induration: mm Date Administered:		☐ Not done ☐ UNK	
Date Read:		Cavity: ☐ Yes ☐ No ☐ UNK	
Epidemiologic Investigation			
Case identified during the contact investigation of another case?: ☐ Yes ☐ No ☐ UNK		If yes: Evaluated for TB during that contact investigation? ☐ Yes ☐ No ☐ UNK	
Date: ☐ Greater than 2 years ☐ Less than or equal to 2 years		Relationship to patient:	
Contact Investigation conducted for this case?: ☐ Yes ☐ No ☐ UNK		Comments:	

Medical History

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Clinical	
Date of clinical assessment:	
Weight: lbs kgs	Height: ft in cm BMI:
Estimated weight, 3 months ago: lbs kg Weight at least 10% < ideal body weight: ☐ Yes ☐ No	
Blood pressure: systolic diastolic	
Date temperature collected: Temperature: F C	
Medical Risk and History	
Date medical history collected:	Comments
Allergies: ☐ Yes ☐ No ☐ UNK	
Arthritis/gout: ☐ Yes ☐ No ☐ UNK	
Use of ☐ Remicade ☐ Humira ☐ Enbrel	
Autoimmune: ☐ Yes ☐ No ☐ UNK	
Cancer: ☐ Yes ☐ No ☐ UNK	
Specify: ☐ Head ☐ Neck ☐ Other, specify:	
Chronic malabsorption syndrome: ☐ Yes ☐ No ☐ UNK	
Chronic renal disease: ☐ Yes ☐ No ☐ UNK	
Corticosteroids (received equivalent of >15 mg/d Prednisone for >1 month): ☐ Yes ☐ No ☐ UNK	
Covid-19 at TB diagnostic evaluation? ☐ Yes ☐ No ☐ UNK	
Diabetic at TB diagnostic evaluation? ☐ Yes ☐ No ☐ UNK	☐ Documented ☐ Self-reported
Diabetes controlled: ☐ Yes ☐ No ☐ UNK	Controlled through: ☐ Pills ☐ Insulin ☐ UNK
Diabetic mellitus: ☐ Yes ☐ No ☐ UNK	☐ Type 1 ☐ Type 2
End-stage renal disease: ☐ Yes ☐ No ☐ UNK	
GI/gastroctomy or jejunioileal bypass: ☐ Yes ☐ No ☐ UNK	
Gynecological: ☐ Yes ☐ No ☐ UNK	
Heart disease/PVD: ☐ Yes ☐ No ☐ UNK	
Hemodialysis: ☐ Yes ☐ No ☐ UNK	Schedule:
HIV/AIDS: ☐ Yes ☐ No ☐ UNK	
Hypertension/CVA: ☐ Yes ☐ No ☐ UNK	
Intellectual disability/developmental delay: ☐ Yes ☐ No ☐ UNK	
Mental illness(es): ☐ Yes ☐ No ☐ UNK	When (select all that apply):
Specify: ☐ Anxiety ☐ Depression ☐ Schizophrenia ☐ UNK	☐ Currently ☐ Within past 12 months ☐ Ever
☐ Other, specify:	
Neurological/seizures: ☐ Yes ☐ No ☐ UNK	
Other immunocompromise (Other than HIV/AIDS): ☐ Yes ☐ No ☐ UNK Specify:	
Other liver disease (not hepatitis B or C): ☐ Yes ☐ No ☐ UNK	
Post-organ transplantation: ☐ Yes ☐ No ☐ UNK	
Postpartum: ☐ Yes ☐ No ☐ UNK	
Respiratory problems: ☐ Yes ☐ No ☐ UNK	
Silicosis: ☐ Yes ☐ No ☐ UNK	
Skin disease: ☐ Yes ☐ No ☐ UNK	
STD: ☐ Yes ☐ No ☐ UNK	
Surgeries/hospitalizations: ☐ Yes ☐ No ☐ UNK	
Thyroid: ☐ Yes ☐ No ☐ UNK	
TNF-alpha antagonist therapy: ☐ Yes ☐ No ☐ UNK	
Viral hepatitis (B or C Only): ☐ Yes ☐ No ☐ UNK	
Vision/hearing disorder: ☐ Yes ☐ No ☐ UNK	
Skin test conversion – increase of 10mm or more within 2 years ☐ Yes ☐ No ☐ UNK	
Incomplete LTBI therapy: ☐ Yes ☐ No ☐ UNK	
Untreated or inadequately treated active TB, including fibrotic changes on X-ray consistent with previous TB: ☐ Yes ☐ No ☐ UNK	
Recently infected with M. tb (within the past 2 years): ☐ Yes ☐ No ☐ UNK	



Symptoms	
TB symptoms screening performed: ☐ Yes ☐ No Is patient symptomatic: ☐ Yes	
Symptom Screening Date:	
Symptom	Date of Symptom Onset
Bloody urine: ☐ Yes ☐ No	Headache: ☐ Yes ☐ No
Chest pain: ☐ Yes ☐ No	Hemoptysis: ☐ Yes ☐ No
Cough/persistent x 3 weeks: ☐ Yes ☐ No	Loss of appetite: ☐ Yes ☐ No
Decreased level of consciousness: ☐ Yes ☐ No	Neck stiffness: ☐ Yes ☐ No
Enlarged cervical lymph nodes: ☐ Yes ☐ No	Night sweats: ☐ Yes ☐ No
Eye pain or blurry vision: ☐ Yes ☐ No	Pain, swelling other locations: ☐ Yes ☐ No
Fatigue: ☐ Yes ☐ No	Productive cough: ☐ Yes ☐ No
Fever/chills: ☐ Yes ☐ No	Swelling of joint/vertebrae: ☐ Yes ☐ No
Flank pain: ☐ Yes ☐ No	Swelling of lymph nodes: ☐ Yes ☐ No
Frequent urination: ☐ Yes ☐ No	Weight loss >10%: ☐ Yes ☐ No
Other, Specify other:	
Source of symptom information: ☐ Patient interview ☐ Relative/friend ☐ Medical record ☐ Other, specify:	Respiratory isolation Date placed in respirator:
Notes:	

TB-202 Tuberculosis Initial Health Risk Assessment/History – Revised 9/1/2026

Psychosocial History

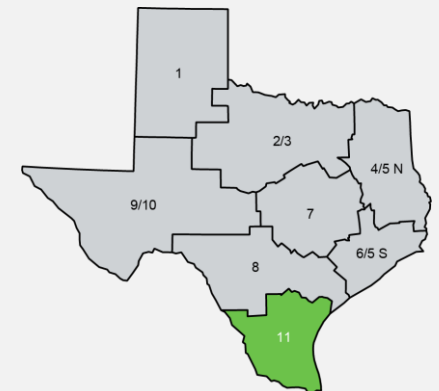
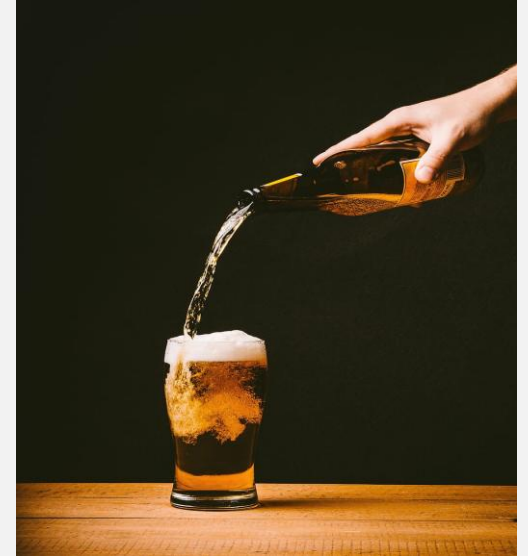
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Social Risk Factors	
Date social risk factors collected:	Comments
Heavy alcohol use in the past 12 months: ☐ Yes ☐ No ☐ UNK In the last 30 days, how many days did the patient have > 4 drinks? ☐ 0-4 days ☐ 5 days or more ☐ UNK	Patient was provided additional resources: ☐ Yes ☐ No
Injecting drug use in the past 12 months: ☐ Yes ☐ No ☐ UNK If yes, specify: ☐ Cocaine ☐ Opioids ☐ Other illicit drug Other:	Patient was provided additional resources: ☐ Yes ☐ No
Non-injecting drug use in the past 12 months: ☐ Yes ☐ No ☐ UNK If yes, specify: ☐ Marijuana ☐ Cocaine ☐ Opioids ☐ Crack ☐ Methamphetamines ☐ Other illicit drug Other:	Patient was provided additional resources: ☐ Yes ☐ No
Current smoking status at diagnostic evaluation: ☐ Current every day ☐ Current someday ☐ Former ☐ Never ☐ Current status UNK ☐ UNK if ever Packs per day/Years of use:	Patient was provided additional resources: ☐ Yes ☐ No

Social Risk Factors

- Alcohol Use
- Drug Use
- Tobacco Use



Environmental Assessment

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- Homelessness
- Incarceration History
- Congregate Settings
- High Risk Occupations
- M. Bovis Risk Factors
- Travel



Homeless in the past 12 months: ☐ Yes ☐ No ☐ UNK	
Homeless ever: ☐ Yes ☐ No ☐ UNK	
Resident of correctional facility at diagnostic evaluation: ☐ Yes ☐ No ☐ UNK Type of correctional facility: ☐ Federal prison ☐ State prison ☐ Local jail (city or county) ☐ Juvenile correctional facility ☐ Other: ☐ UNK	
Under custody of immigration and customs enforcement (ICE): ☐ Yes ☐ No ☐ UNK	
Resident of correctional facility ever: ☐ Yes ☐ No ☐ UNK	
Resident of long-term care facility at diagnostic evaluation: ☐ Yes ☐ No ☐ UNK If Yes, type of long-term care facility: ☐ Nursing home ☐ Hospital-based facility ☐ Residential facility ☐ Mental health residential facility ☐ UNK ☐ Alcohol or drug treatment facility ☐ Other, specify:	
Resident of other congregate setting at diagnostic evaluation: ☐ Yes ☐ No ☐ UNK If yes, specify: ☐ Colonia ☐ Displaced citizen ☐ School dorm ☐ Unaccompanied alien child/minor (UAC) ☐ Homeless Shelter ☐ Other, specify ☐ UNK	
Low income: ☐ Yes ☐ No ☐ UNK	
Inner-city resident: ☐ Yes ☐ No ☐ UNK	
Patient lived outside US for >2 months (uninterrupted): ☐ Yes ☐ No ☐ UNK Countries:	
Employee of high risk congregate setting or institution: ☐ Yes ☐ No ☐ UNK	
Has the patient ever worked as one of the following: ☐ Healthcare worker ☐ Correctional facility employee ☐ Migrant/seasonal worker ☐ None of the above ☐ UNK ☐ Other, specify	
Current Occupation for all patients ≥14 years of age: Current industry:	
Contact to infectious TB patient (2 years or less): ☐ Yes ☐ No ☐ UNK	
Contact to MDR-TB case (2 years or less): ☐ Yes ☐ No ☐ UNK	

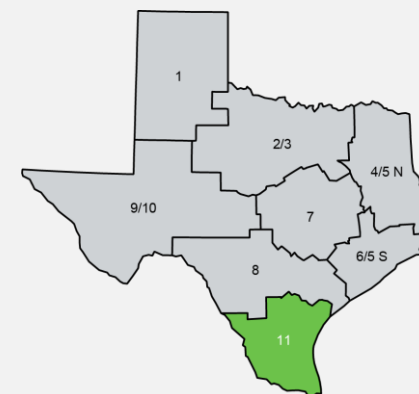
Summary

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- Develop a plan of care with patient involvement
- Ongoing assessment throughout the course of treatment
- Reevaluate as needed for a successful completion of treatment



Thank you!

TB Nurse Assessment

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