TUBERCULOSIS SKIN TEST SCREENING/CONSENT FORM

Today's Date:_____

Patient: _____ Date of Birth: _____
Last Name First MI

	Yes	No
1. Have you ever had a TB Skin Test? If yes, Date of last Test: _____	☐	☐
2. Have you ever had a positive reaction? **If yes, do not administer TB Skin Test. Chest Xray must be ordered.*	☐	☐
3. Have you ever received BCG Vaccine?	☐	☐
4. Have you ever had Tuberculosis?	☐	☐
5. Have you ever had contact with and/or been exposed to anyone with tuberculosis?	☐	☐
6. Has a doctor advised you or is there any reason that you should not have a TB Skin Test	☐	☐

If yes, why?_____

7. Do you currently have any of the following symptoms?

	Yes	No
Unexplained fatigue for more than 2 weeks?	☐	☐
Unexplained persistent cough?	☐	☐
Coughing up blood?	☐	☐
Unintentional weight loss?	☐	☐
Unexplained fever?	☐	☐
Night sweats?	☐	☐

I hereby certify that the above answers are true to the best of my knowledge. I understand I must return in 48 to 72 hours for a TB reading for this test to be considered valid. If not read within these parameters, the test will need to be repeated. I understand the most common side effects to be pain or redness at site of administration; serious side effects are rare but may include blistering or skin wound in individuals hypersensitive to the solution. I hereby give permission for the TB Skin Test.

_____ _____
Signature of Patient or Parent/Guardian Date

For Clinic Use Only

Date Given		**Time Given**	
Given By			
Lot Number		**Injection Site**	☐Right ☐Left Forearm
Expiration Date		**Manufacturer**	
Date Read		**Time Read**	
Read By			
Result	☐ Negative ☐ Positive	**Induration**	_____mm
Action Required		**Date of Follow-up**	