TUBERCULOSIS ASSESSMENT/SKIN TEST CONSENT

	YES	NO
1a) Have you ever had a positive reaction to a T.B. skin test? (If answer is yes, please consult the Provider)	( )	( )
1b) If you had a positive T.B. skin test, did you get a chest X-ray? When_____ Where_____ Results? _____	( )	( )
1c) Have you ever been treated for TB? When_____ With What Medication_____ For How Long? _____	( )	( )
2) Does a household member have a history of confirmed or suspected T.B?	( )	( )
3) Were you born or traveled outside the United States?	( )	( )
4) Have you or a household member ever been incarcerated (jailed) or been in an out-of-home placement such as a homeless shelter, board and care or nursing home?	( )	( )
5) Have you or a household member ever been homeless?	( )	( )
6) Have you or a household member ever had a history of street drug abuse?	( )	( )
7) Do you or a household member have a suspected or confirmed HIV infection?	( )	( )
8) Have you had pneumonia in the past year?	( )	( )
9) In the last year, have you had any of the following symptoms?	( )	( )

	YES	NO
Coughing up blood	( )	( )
Hoarseness lasting three weeks or more	( )	( )
Persistent cough lasting three weeks or more	( )	( )
Persistent fever lasting three weeks or more	( )	( )
Unexplained Excessive sweating at night	( )	( )
Unexplained weight loss	( )	( )

BASED ON YOUR HISTORY, YOU ☐ DO ☐ DO NOT NEED A T.B. SKIN TEST. ***OR***

SCHEDULE A ☐ CHEST X-RAY Provider Initials_____ Date_____

* * * *VERY IMPORTANT - PLEASE READ IF YOU ARE RECEIVING A T.B. TEST* * * *

YOU MUST RETURN TO THIS OFFICE ON_____ TIME:_____ SO WE CAN LOOK AT THE TEST SITE ON YOUR ARM. IF YOU DO NOT COME IN ON THAT DATE, THE TEST WILL NEED TO BE REPEATED AFTER 6 WEEKS. IF YOU HAVE ANY QUESTIONS, PLEASE ASK OUR STAFF BEFORE THE TEST.

PLEASE SIGN THAT YOU HAVE READ AND UNDERSTAND THIS INSTRUCTION.

DATE:_____ SIGNATURE:_____

************FOR OFFICE USE ONLY************

DATE OF TEST:_____ TIME:_____ LOCATION: ☐L. FOREARM ☐R. FOREARM

TEST DONE BY:_____ ☐ RN ☐LVN ☐MA

DATE TEST SITE OBSERVED:_____ TIME:_____ BY: _____

SKIN CLEAR: ☐YES ☐NO INDURATION: _____MM

NOTE: IMMEDIATELY REFER INDURATION OVER 5MM TO A PROVIDER OR R.N.

PROVIDER OR R.N. IMPRESSION: ☐ POSITIVE ☐ NEGATIVE

CXR ORDERED ☐YES ☐NO DATE DONE:_____ RESULT ☐NEG ☐POSITIVE

R.N. OR PROVIDER SIGNATURE _____ DATE:_____

PATIENT NAME:_____

DOB:_____

MR#_____