

<b>PATIENT NAME</b> (Last)	(First)	(M.I.)
<b>MRN</b>	<b>DOB</b>	<b>AGE</b>

**TUBERCULOSIS:** Mycobacterium tuberculosis (TB) is a disease which is carried through the air in small particles when people who have active TB cough, sneeze, speak, or sing. It usually affects the lungs but can also affect the heart, kidneys, bones, and other organs of the body. The Tuberculosis Skin Test is a way of identifying TB infection. You cannot get TB from the skin test.

**RISKS & POSSIBLE SIDE EFFECTS:** If you have been exposed to TB in the past, swelling and redness may develop at the site of the test. A blister or scar may also result. The TB skin test should not be given to persons who have had a positive reaction in the past, or who have had an active case of TB, or who have taken TB medications in the past. If this has happened to you, please tell the Clinical Staff prior to taking the skin test. Since there is no reliable method of distinguishing tuberculin reactions caused by BCG (bacille Calmette-Guerin) vaccine from those caused by natural infections, if you have received BCG vaccine (given in foreign countries) it is not a contraindication for receiving the TB skin test. The test would be given and interpreted routinely.

**RETURN FOR READING:** Return to have test read in 2-3 days (no less than 48 hours; no greater than 72 hours). Failure to have the test read will necessitate repeating the test.

**Please answer the following for yourself/your child:**

- A positive reaction to a TB skin test? If so, when \_\_\_\_\_  Yes  No
- A severe reaction to a previous Tuberculin Skin Test? .....  Yes  No
- Any vaccine administered in the previous 4 weeks (28 days)? If so, what \_\_\_\_\_  Yes  No
- Cough lasting more than 3 weeks? .....  Yes  No
- Deep cough that brings up mucus 5 times or more per week?.....  Yes  No
- Unexplained night sweats (2-3 times per week)? .....  Yes  No
- Unexplained weight loss (5 or more pounds)? .....  Yes  No
- Unexplained chest pain?.....  Yes  No
- If the answer to any of the questions is YES, please explain \_\_\_\_\_

**PATIENT ACKNOWLEDGEMENT:** I have read the above information. I have had an opportunity to ask any questions, which have been answered to my satisfaction. I understand the benefits and risks of the TB Skin Test. I request that the TB Skin Test be given to me or the person named above for whom I am authorized to sign.

<b>SIGNATURE</b> (Guardian if under 18)	<b>DATE</b>
<b>PARENT/GUARDIAN NAME</b> if under 18 (Last)	(First)
	<b>RELATIONSHIP</b>

**FOR CLINIC USE ONLY**

PPD PLACEMENT						
Date	Time	Solution	Dose	Route Intradermal	Lot Number	Expiration
		Tubersol®	0.1 mL	<input type="checkbox"/> L. Forearm <input type="checkbox"/> R. Forearm		

Signature: \_\_\_\_\_ Verified by: \_\_\_\_\_ if administered by MA)

SKIN TEST READING		
Date	Time	Results
		<input type="checkbox"/> No Induration <input type="checkbox"/> Induration: _____ mm x _____ mm (Do not measure redness) <input type="checkbox"/> Negative <input type="checkbox"/> Positive (To be determined by Licensed Clinical Staff only)

Test Read by Signature: \_\_\_\_\_ Clinic: \_\_\_\_\_