PARAMOUNT URGENT CARE

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TB SKIN TEST (P.P.D.) QUESTIONNAIRE & CONSENT

Date:___/____/_____ Name:_____ DOB:___/_____/____

You will be given a skin test for Tuberculosis. Circle one answer below.

1.) Have you had a TB skin test in the past? **Y N**
2.) If yes, were you told it was "positive" or was there any redness or swelling? **Y N**
3.) Have you ever had a BCG vaccine (given in countries outside of the U.S.?) **Y N**
4.) Have you or any of your family members been exposed to active TB? **Y N**
5.) Have you had a viral illness or received any vaccinations in the past four (4) weeks? **Y N**
6.) Do you currently take cancer medicine or steroids? **Y N**
7.) Are you pregnant or nursing*? **Y N**

IF YOU ARE PREGNANT OR NURSING, YOU WILL NEED PERMISSION FROM YOUR PHYSICIAN PRIOR TO TAKING THIS TEST

By signing below I am acknowledging that I have been given information and an opportunity to ask questions about PPD TB skin test, and now consent to receiving the test.

Patient Signature_____ Date_____/_____/_____

*****PLEASE BE AWARE, you MUST return to the office after 48-72 hours to check the area for a positive or negative reading. After the 72 hours has expired the test now becomes invalid and another PPD TB skin test will need to be performed*****

MUST RETURN AFTER AM/PM ON AND/OR BEFORE AM/PM ON

FOR OFFICE USE ONLY: *****TEST # 1*****

DATE: _/_____/_____ MFG:_____LOT#:_____
TIME: _____AM/PM EXP DATE:____/____/_____

ARM: RIGHT LEFT PRACTITIONER:_____

RESULTS:

NEGATIVE POSITIVE_____mm CXR _____

PRACTITIONER:_____DATE:___/___/____TIME:_____AM/PM

MUST RETURN AFTER AM/PM ON AND/OR BEFORE AM/PM ON

FOR OFFICE USE ONLY: *****TEST # 2*****

DATE:___/_____/_____ MFG:_____LOT#:_____
TIME: _____AM/PM EXP DATE:____/____/_____

ARM: RIGHT LEFT PRACTITIONER:_____

RESULTS:

NEGATIVE POSITIVE_____mm CXR _____

PRACTITIONER:_____DATE:___/___/____TIME:_____AM/PM