

TUBERCULOSIS ASSESSMENT/SKIN TEST CONSENT

CIRCLE	AP	AF	BH	FL	FR	GG	LB	LA6th	PM	SAM	TO	VN
TEST SITE												

- | | | | |
|-----|---|------------|-----------|
| | | YES | NO |
| 1a) | Have you ever had a positive reaction to a T.B. skin test? | () | () |
| | (If member's answer is yes, please consult the Provider) | | |
| 1b) | If you have had a positive T.B. skin test, did you get a chest X-ray? | () | () |
| | When _____ Where _____ Result? _____ | | |
| 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 or a household member born in Asia, Africa, Mexico, Central or South America? | () | () |
| 4) | Within the past five years, have you or a household member been incarcerated (jailed) or been in an out-of-home placement such as a homeless shelter 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? | () | () |

BASED ON YOUR HISTORY, YOU DO DO NOT NEED A T.B. SKIN TEST AT THIS TIME.
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# _____