

**TUBERCULOSIS ASSESSMENT/SKIN TEST CONSENT**

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

- |     |   |            |           |
|-----|---|------------|-----------|
|     |   | <b>YES</b> | <b>NO</b> |
| 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# \_\_\_\_\_