TUBERCULOSIS TEST FORM

Patient Name: ____ SSN: _____________________________________

Please answer these questions:

Have you taken steroids within the last 10 days? *Yes* ____________ *No* ____________

Have you had a positive reaction to a TB skin test? *Yes* ____________ *No* ____________

Have you had an allergic reaction to a TB skin test? *Yes* ____________ *No* ____________

Have you had a BCG vaccination for TB? *Yes* ____________ *No*____________

Bacillus of Calmette-Guerin used for immunization against tuberculosis in exposed TB skin test negative infants and children.)

If you answered YES to any of the above questions, have you since received:

TB skin test? Yes _____ *No* _____

*Chest X-ray? Yes*_____*No* _____

Chest X-ray result: ____

Did you receive treatment? Yes _____ *No*_____ *If yes, type of treatment:* ____

<u>PATIENT INSTRUCTIONS</u>:

A TB skin test is given to screen people for tuberculosis. A reaction to this test does not necessarily mean that you have tuberculosis. It is important however to have the test site examined within the timeframe of 48 to 72 hours. If it has been more than 72 hours since the test was administered, the test will have to be repeated and you may be responsible for the cost of a repeat test.

DO NOT put a bandage or lotion on the test site. It is okay to get the site wet but do not wipe or scrub the test site. If it itches, you may put a cold compress on the area.

Your test will not be read before (date/time):______________________ (am/pm) or after (date/time):_____________________ (am/pm).

Patient Signature: ____ Date: ____

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TEST INFORMATION:

Designated placement for the TB skin test: (circle) **<u>right</u>** or **<u>left</u>** anterior aspect of the forearm.

IPPD Skin Test Lot #: __________________ Expiration Date: _____________________

Date Given: __________________________ Time Given: ________________________ (am/pm)

Nurse/Clinician: ____

Test Results/Interpretation: *(Document all readings in numerical format*)

Negative: __________mm Positive: __________mm induration (measure)

Date Read: ____________________________Time Read: __________________________ (am/pm)

<u>Positive Test</u>: Test results have been discussed with patient. TB Clinic referral sheet reviewed and given to patient. A copy of this sheet has been provided. Patient verbalized understanding of need for follow up. _________ Patient Initials

Reader Signature: ____ Date: ____