TUBERCULOSIS SKIN TEST (TST) SCREENING FORM

Name: ________________________________  (  ) Employee (  ) Medical Staff

I agree to have 0.1 mL Mantoux tuberculin skin test (TST) administered intradermally (under the skin) in my forearm. I understand that I must return in 48 – 72 hours to have each test read, or I will need to have the test repeated.

Signature: ____________________________  Date: ____________________________

Reason for Test:
Annual Screening ______
Possible Exposure ______
Other (please explain) ____________________________________________________________

Have you ever had any of the following?
____ Positive TB skin test
____ Taken medication for tuberculosis
____ Been told you had tuberculosis germ in your body
____ Been exposed to anyone with active tuberculosis disease
If history of contact or previous positive TB skin test, please give details and document any signs and symptoms of TB disease.
_____________________________________________________________________________________

Date of 1st TST _____________________________  Site: ____________________________
Nurse administering TST: ____________________________
PPD Manufacturer: __________________ Lot Number: __________________ Expiration date: ____________
Date of Reading: _________________________________
Results of Reading: _________________________________
Nurse Reading Results: __________________________ mm’s
_____________________________________________________________________________________

Date of 2nd TST _____________________________  Site: ____________________________
Nurse administering TST: ____________________________
PPD Manufacturer: __________________ Lot Number: __________________ Expiration date: ____________
Date of Reading: _________________________________
Results of Reading: _________________________________
Nurse Reading Results: __________________________ mm’s

Refer to Annual TB Screening Policy for TST Interpretation Guidelines       Effective: