COLLEGE OF MARIN

HEALTH CENTER, KENTFIELD, 415.485.9458

TUBERCULOSIS SKIN TEST RECORD

PLEASE READ ENTIRE FORM CAREFULLY.

______________________________ SEX: ❏ M ❏ F

NAME (last, first, MI)

ADDRESS (number and street) CITY STATE ZIP

DAY PHONE BIRTHDATE AGE

REASON FOR TEST

❏ Employment at COM: ______________ OCCUPATION

❏ ESL
❏ Foreign Student–F1
❏ RN Program

❏ Dental Asst. Program
❏ EMT Program
❏ Medical Asst. Program

❏ Other: ______________

PLEASE READ AND ANSWER THE FOLLOWING CAREFULLY. All answers are CONFIDENTIAL and are necessary for accurate TB test interpretation.

Date of last TB test: ________ ❏ Neg. ❏ Pos. Date of last chest x-ray: ________ ❏ Neg. ❏ Pos.

❏ No ❏ Yes Date ________ Have you ever had a positive skin test?
❏ No ❏ Yes Date ________ Have you ever taken medications for TB?
❏ No ❏ Yes Date ________ Have you ever had BCG vaccination? (BCG is a vaccine for TB given in some countries on upper arm.)
❏ No ❏ Yes Date ________ Have you ever had exposure to any person with known active TB disease?
❏ No ❏ Yes Date ________ Have you ever been significantly underweight or had a recent weight loss?
❏ No ❏ Yes Date ________ Have you ever been on steroids (prednisone) longer than 2 weeks?
❏ No ❏ Yes Date ________ Have you recently had any of these symptoms i.e. cough, night sweats, fatigue, unexplained weight loss or fever?
❏ No ❏ Yes Date ________ Have you had a viral illness within last 6 weeks?
❏ No ❏ Yes Date ________ Have you had any live virus vaccine within last 6 weeks i.e. mumps, measles, rubella, varicella?
❏ No ❏ Yes Date ________ Are you pregnant or nursing?
❏ No ❏ Yes Date ________ Are you currently taking any medication? If yes, please list or verbally tell us:

Medications: ______________________________

State or country of birth: ______________________ Date arrived in U.S.: ______________________

What countries have you visited or lived in (with dates)? ______________________

Past occupations where you worked with large numbers of people, i.e., jails, schools, healthcare facilities:

____

Current or significant past medical problems: ______________________________

PLEASE TELL US IF YOU HAVE ANY CONDITION WHICH AFFECTS THE IMMUNE SYSTEM (such as HIV or cancer). The test is interpreted differently in those patients—all information is CONFIDENTIAL—you may notify us verbally if you wish. Please put a check by any of the following that apply to you or any of your previous or current sex partners. If you prefer, you may notify us verbally.

❏ No ❏ Yes Serious exposure to blood or blood products
❏ No ❏ Yes Transfusion before 1985
❏ No ❏ Yes Sex partner of HIV positive person
❏ No ❏ Yes Injecting drug user
❏ No ❏ Yes Unsafe sex practices (not using barrier methods)
❏ No ❏ Yes A sexually transmitted disease
❏ No ❏ Yes Exchanged sex for drugs or money
❏ No ❏ Yes Have had sex with a person of same sex or bisexual partner
❏ No ❏ Yes Been homeless within past 5 years
❏ No ❏ Yes Been incarcerated in prison

I consent to be tested for TB and acknowledge that the above medical information is complete to the best of my knowledge. I am aware that if I test positive, the information contained on both sides of this form and any subsequent x-ray reports must be reported to the Marin County Health Department TB Clinic. If I test positive, I may choose to be followed by the COM Health Center, County Health Department TB Clinic or my private physician and consent to the release of the above medical records to the health care provider of my choice.

Signature of Consent: ______________________________ Date: ______________

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TUBERCULOSIS SKIN TEST RECORD

STAFF USE ONLY

INTRADERMAL PPD 5 TU 0.1 ML

Lot No.________________ Manufacturer____________________________ Exp. Date__________

Date applied ____________ By ______________________ Location applied ____________________

Date read ______________ By ______________________ Result _____ mm Induration ❑ Negative ❑ Positive

BOOST

Lot No.________________ Manufacturer____________________________ Exp. Date__________

Date applied ____________ By ______________________ Location applied ____________________

Date read ______________ By ______________________ Result _____ mm Induration ❑ Negative ❑ Positive

CXR (if applicable)

Ordered: ❑ Yes ❑ No Referred to ______________________ By __________________ Date __________

MCHD NOTIFIED (if applicable)

By ____ Date ____________ (copy CMR in file)

COPY OF TB ENTERED IN BANNER (if applicable)

By ____ Date ______________________

PROGRESS NOTES