



## **TUBERCULOSIS (PPD) SCREENING RECORD**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

**Please answer the following questions:**

**Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Yes    No**

- |                          |                          |                                                             |
|--------------------------|--------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a cough that has lasted 3 weeks or more?        |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently experiencing chest pain?                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently experiencing shortness of breath?         |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a fever or experiencing chills?                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever tested positive for TB before?                |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had the BCG vaccine (TB Vaccine from Europe)? |

I understand that it is my responsibility to have a tuberculin skin test reading within 48 to 72 of the date & time of administration and that failure to have a reading within this time may require a new test to be administered at my expense.

\_\_\_\_\_  
Patient Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

### **Test Administration & Reading:**

#### **STEP 1:**

**Tuberculin Manufacturer:** \_\_\_\_\_

**Lot #:** \_\_\_\_\_ **Exp. Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Administered:** \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_:\_\_\_\_ am pm

**Location of implantation:** ☐ left forearm ☐ right forearm

**Administered By:** \_\_\_\_\_

**Reading:** \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_:\_\_\_\_ am pm

**Results:** \_\_\_\_\_mm induration

**X-Ray Required?** ☐ Yes ☐ No

**Read By:** \_\_\_\_\_

#### **STEP 2:**

**Tuberculin Manufacturer:** \_\_\_\_\_

**Lot #:** \_\_\_\_\_ **Exp. Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Administered:** \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_:\_\_\_\_ am pm

**Location of implantation:** ☐ left forearm ☐ right forearm

**Administered By:** \_\_\_\_\_

**Reading:** \_\_\_\_/\_\_\_\_/\_\_\_\_    \_\_\_\_:\_\_\_\_ am pm

**Results:** \_\_\_\_\_mm induration

**X-Ray Required?** ☐ Yes ☐ No

**Read By:** \_\_\_\_\_

**Injection site must be read within 48-72 hours of date/time of injection.**