PROVIDENCE
Healthcare Network

Consent for TB Skin Test

Patient Name: _____ DOB: _____ Today's Date: _____

This includes a TB skin test and the completion of this questionnaire. Check yes or no to the questions below. If any answer is yes, give the approximate date the symptoms started and whether or not you still have them.

Have you had any vaccinations in the past 4 weeks? ☐Yes ☐No If yes, what vaccination? _____

Have you had any of the following symptoms in the past year?

Productive cough for 3 weeks or more	☐Yes	☐No	Date symptom began: _____
Persistent weight loss without dieting	☐Yes	☐No	Date symptom began: _____
Fever that exceeds 100°F for more than 3 weeks	☐Yes	☐No	Date symptom began: _____
Unexplained, excessive sweating at night	☐Yes	☐No	Date symptom began: _____
Loss of appetite	☐Yes	☐No	Date symptom began: _____
Swollen glands in neck or elsewhere	☐Yes	☐No	Date symptom began: _____
Recurrent/persistent kidney/bladder infections	☐Yes	☐No	Date symptom began: _____
Coughing up blood (hemoptysis)	☐Yes	☐No	Date symptom began: _____
Shortness of breath	☐Yes	☐No	Date symptom began: _____
Chest pains	☐Yes	☐No	Date symptom began: _____
Unexplained fatigue/weakness or feeling ill	☐Yes	☐No	Date symptom began: _____
Frequent or recurring chills	☐Yes	☐No	Date symptom began: _____
Hoarseness for 3 weeks or more	☐Yes	☐No	Date symptom began: _____

The above questions have been answered to the best of my knowledge. If any of the symptoms questions were answered as yes, the patient will need to contact their primary care provider for further assessment and administration of any testing.

Consent for TB Skin Test: I, _____, consent for the above patient to have a PPD Tuberculosis skin test. I release Providence Health Alliance and its employees from all liability in connection with the administration and interpretation of this test.

Patient/Parent Signature: _____ Date: _____

Witness: _____ Date: _____

DO NOT WRITE BELOW THIS LINE

Lot #: _____ *Exp. Date:* _____ *Manufacturer:* _____

Standard intradermal dose of 0.1 ml tuberculin skin test

Date Test Given: _____ By: _____

Date Test Read: _____ By: _____

Coloration: _____ Red _____ Bruised _____ Raised Results/Induration Size: _____MM

RETURN FOR READING 48-72 HOURS AFTER THE TEST HAS BEEN ADMINISTERED.

Return Date for Test Reading: _____