ROUTINE TUBERCULOSIS TESTING / FOLLOW-UP SCREENING

NAME: _____

Can be done by primary MD, community clinic, school health service. Bring this form with you to have Mantoux placed.

To be completed by patients with a history of **Negative TST**	To be completed by patients with a history of **Positive TST** (or told by healthcare provider that they can no longer have a TB test)
Tuberculin Skin Test Number 1 (PPD 5 T.U. Intradermal) Date given: _____ ☐ Aplisol ☐ Sanofi ☐ Other: Lot #: _____ Site: ☐ Right forearm ☐ Left forearm ☐ Other: Given by: _____ Clinic: _____ Must be read in 48 to 72 hours by your designated reader. Self-reading is not acceptable **TST Results for Test Number 1** Date read: _____ Reading: _____ mm induration Read by: _____ Clinic: _____ ***Tuberculin Skin Test Number 2*** (PPD 5 T.U. Intradermal) Date given: _____ ☐ Aplisol ☐ Sanofi ☐ Other: Lot #: _____ Site: ☐ Right forearm ☐ Left forearm ☐ Other: Given by: _____ Clinic: _____ Must be read in 48 to 72 hours by your designated reader. Self-reading is not acceptable **TST Results for Test Number 2** Date read: _____ Reading: _____ mm induration Read by: _____ Clinic: _____	**POSITIVE MANTOUX SURVEY** Fill in the information below **only** if you have a history of positive TST. **In the past year, have you had any of the following symptoms for greater than 1 to 2 weeks?** Cough ☐ Yes ☐ No Change in cough ☐ Yes ☐ No Loss of appetite ☐ Yes ☐ No Night sweats ☐ Yes ☐ No Fatigue ☐ Yes ☐ No **In the last year, have you ever had:** Bloody sputum ☐ Yes ☐ No Exposure to TB ☐ Yes ☐ No **Comments:** **Signature of Healthcare Provider:** _____