Nursing Assessment for TB Skin Testing

First Name _____ Last Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex _____ Race/Country of Origin _____

Physician _____ Reason for TB skin test _____

Test Requested: ☐ 1 Step ☐ 2 Step (check one)

	1st Step		2nd Step	
	Yes	**No**	**Yes**	**No**
1. Have you recently been in contact with someone with active TB disease?				
2. Have you had a TB test in the past?				
3. If you had a TB test in the past, were the results positive?				
4. Have you ever received medications or treatment for TB?				
5. Have you ever had an adverse (vesiculation, ulceration, necrosis) or severe allergic reaction to a TB skin test?				
6. Have you had any recent illnesses or infections?				
7. Do you have any medical conditions?				
8. Are you currently or have you recently taken organ transplant drugs, cortisone, prednisone, or other steroids, or had radiation.				
9. Is there any reason you think your immunity/resistance is low (HIV+, cancer, leukemia, diabetes, renal disease, past gastric surgery, unintentional weight loss, etc.)?				
10. Have you received any live vaccines in the past four to six weeks (MMR, oral polio, varicella, yellow fever, oral typhoid, BCG)? If history of BCG, when _____				
11. **Women Only:** Are you pregnant or is there a possibility of becoming pregnant?				
12. Are you able to return in 48 to 72 hours to have the test read?				

Comments:

_____

_____

Please read and sign the following:

I have read, or have had explained to me in a language and a way that I understand, the information about the Mantoux Tuberculin Skin Test. I have had a chance to ask questions which were answered to my satisfaction. I agree to return in 48 to 72 hours to have the test read. I understand the benefits and risks of the test and request that the test be given to me or to the person above for whom I am authorized to give consent. I understand that my Tuberculin Skin Test results may be communicated to the physician with whom I will follow up if medical care is necessary.

1ST Step _____ _____

Signature *Date* *Signature of Parent/Guardian* *Date*

2nd Step _____ _____

Signature *Date* *Signature of Parent/Guardian* *Date*

Tuberculin Skin Test Record

1st Step

Manufacturer & Lot Number	
Manufacturer Exp. Date	
Date & Time test applied	_____/_____/_____ _____:_____ ☐ **AM** ☐ **PM**
Site of injection	☐ **LFA** ☐ **RFA**
Signature & Title of person placing skin test	
Results/Date & Time	_____/_____/_____ _____:_____ ☐ **AM** ☐ **PM**
Signature & Title of person reading skin test	

2nd Step

Manufacturer & Lot Number	
Manufacturer Exp. Date	
Date & Time test applied	_____/_____/_____ _____:_____ ☐ **AM** ☐ **PM**
Site of injection	☐ **LFA** ☐ **RFA**
Signature & Title of person placing skin test	
Results/Date & Time	_____/_____/_____ _____:_____ ☐ **AM** ☐ **PM**
Signature & Title of person reading skin test	