Montgomery County Government
Occupational Medical Services
255 Rockville Pike Suite 125
Rockville MD 20850
240-777-5118 (Phone)
240-777-5185 (Fax)

TUBERCULIN SKIN TEST (TST) REPORT

Name: _____ Date: _____

Date of Birth _____ Sex: ❑ Male ❑ Female

Phone: ( ) _____ - _____ Department: _____

Reason for Testing: ❑ Preplacement ❑ Annual ❑ Post Exposure

QUESTIONS

1. Have you ever had a **TB** skin test before? ❑ Yes ❑ No ❑ I do not know

   If yes, was it ever positive ❑ Yes ❑ No ❑ I do not know

   If it was positive, how long ago and where did you receive this test: _____

   Did you receive any treatment or medication for TB? _____

Do you have any of the following:

a. Sensitivity / allergy to PPD serum? ❑ Yes ❑ No
b. Received polio vaccine in the last 4-6 weeks? ❑ Yes ❑ No
c. Received MMR in the last 4-6 weeks? ❑ Yes ❑ No
d. Received varicella vaccine in the last 4-6 weeks? ❑ Yes ❑ No
e. Receiving corticosteroid/other immunosuppressive therapy? ❑ Yes ❑ No

3. Have you ever received **BCG** vaccine? ❑ Yes ❑ No

   If yes, how long ago and where did you receive this inoculation: _____

*****You must return within 48-72 hours to have the test results read. *****

Return On: _____ **After:** _____ **OR** ___/___/___ **Before:** _____

I have read and understand that these are the only times in which this TB test will be accurately read.

Patient Consent Statement: I certify that I have read the information on this form. I have had an opportunity to ask related questions and my questions were answered to my satisfaction. I believe that I understand the benefits and risks of taking a tuberculin test and I assume the risks. I request that the tuberculin test be given.

Signature: _____ **Date:** _____

*****The patient named above has been tested for exposure to Tuberculosis using Purified Protein Derivative diluted to equal standard 5 Tuberculin in Units, in the amount of 0.1cc intradermally. This is the standard Mantoux test.

Date of Placement: ___/___/___ Time of Placement: _____

Location of Placement: ❑ Right Forearm ❑ Left forearm ❑ Other Site: _____

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

Placed By: _____ **M.A. / L.P.N. / R.N. / N.P. / M.D.**

Date of Reading: ___/___/___ Time of Reading: _____ _____

RESULTS: ❑ Negative ____MM ❑ Positive ____MM

❑ This person has completed negative (0mm) testing. ❑ Incomplete testing, failed to return at specified time.

❑ Requires 2-step testing ❑ Yes ❑ No Return for #2 on _____/_____/_____

❑ Chest X-ray done ❑ Yes ❑ No Result: _____

❑ Referred to PMD or County Health Department for possible medication and/or treatment

Reading Completed By: _____ **M.A. / L.P.N. / R.N. / N.P. / M.D.**

Printed Name: _____ **M.A. / L.P.N. / R.N. / N.P. / M.D.**