Missouri Department of Health and Senior Services
TUBERCULOSIS TESTING RECORD

A. PATIENT INFORMATION

Name (Last, First, Middle Initial)		Phone Number

Inmate Number	Student Id Number	Social Security Number

Address/Street	City	Zip code

County	Date of Birth	Sex □ Male □ Female

Occupation

Place of Employment

Race: □ White □ Black □ Asian/ Pacific Islander □ Am. Indian/Alaskan Native

Ethnic Origin: □ Hispanic □ Non-Hispanic

Alien Number   DCN Number

B. HISTORY OF TUBERCULOSIS TEST

Have you ever had a BCG Vaccine?
□ No □ Yes □ Unknown

Have you ever had a Tuberculin test
□ No □ Yes □ Unknown   When/Date

Results in **mm** of previous skin test   Type of test

C. CURRENT TUBERCULIN PPD MANTOUX TEST (S) /X-RAYS

Date administered	Manufacturer	Date administered	Manufacturer
Results in mm	Lot Number	Results in mm	Lot Number
Date Read	Admin. Signature	Date Read	Admin. Signature

Chest X-Ray Done: □ No □ Yes   Date Done:
Results: □ Normal □ Abnormal   Findings:

D. HEALTH CARE PROVIDER

Name/Facility

Address   Phone Number

REPORTED BY

Name   Phone Number

Facility   Report Date

Address

E. Reason for Testing

□ Contact to TB Case   □ Employment   □ Medically Referred   □ Symptomatic
□ Immigration   □ Insurance   □ Educational enrollment   □ Resident   □ Other
Employer/Residence:
□ Long Term Care Facility   □ Department of Corrections   □ Health Care Facility
□ Substance Abuse Center   □ School/Day Care   □ County Jail   □ Other

Client's/Guardian Signature   **Date**

I consent to a tuberculin skin test for the above reasons(s). I understand I am to have the skin test read in 48-72 hours by the designated reader/interpreter.

F. Risk Factors

Please Check all that apply:

□ Contact to TB Case —
□ High   □ Medium   □ Low

□ I.V. Drug User
□ Homeless
□ Migrant Worker
□ Diabetes Mellitus
□ Silicosis
□ Provide health care service
□ Teaches high risk groups
□ No known risk factors
□ Immunosuppressed

□ Foreign Born where TB is Common
□ Employee of Dept of Corrections
□ Employee of Other Correctional Facility
□ Employee of Long Term Care Facility
□ Employee of Mental Health Facility
□ Resident of Dept of Corrections
□ Resident of Other Correctional Facility
□ Resident of Long Term Care Facility
□ Resident of Mental Health Facility

□ Alcoholic
□ Abnormal Chest X-ray
□ Younger than 4 years of age
□ Underserved/Low income
□ Post-gastrectomy
□ Prolonged corticosteriod therapy
□ 10% or more below ideal body weight
□ Skin test converter with 2 years

G. Treatment/Recommendations

Status: □ Close □ Open
□ No □ Yes

Latent TB Infection (LTBI):
Medication Provided by:
□ Private Provider   □ Health Dept

H. Medication

Drug/mg
□ INH   □ B-6   □ Rifampin
□ Other

Frequency	□ Daily □ 2 or 3 times weekly
Duration	(In Months)
Start Date	

Comments:

Reason Treatment not Started
□ Patient Refuses Therapy
□ Physician did not order
□ Medical Contraindication