Infiniti Home Health Care
T. B. TEST FORM

NAME _____ PHYSICIAN _____

ADDRESS _____

TELEPHONE _____ BIRTHDATE _____ SEX ___M ___F

SUPERVISOR _____

The Tuberculin Test is a skin test that tells if a person has been exposed to tuberculosis. The test can discover an infection early, before any damage can be seen by x-ray. Spread of tuberculosis can be prevented by finding unknown cases with the test. Re-testing or x-ray, as appropriate, will be available for all persons who have positive tests. Rarely, persons with positive skin tests experience uncomfortable swelling and redness at the area of the skin test.

I have read the above information and hereby consent to and therefore request the provisions of services encompassing routine procedures and actions as are necessary and desirable in the exercise of professional judgment. I acknowledge that no guarantees have been made to me as to the result of the procedures and actions taken. Such consent is given to Infiniti Home Health Care, LLC for provision of services to the individual listed above.

Signature _____ Date _____

Witness _____ Date _____

---------- FOR CLINIC USE ONLY ----------

Test date/time Site Signature Read (Circle one) 48 hrs / 72 hrs Signature

_____ _____ _____ _____

(Dose manufacturer _____ Lot# _____ Exp. Date _____)

Test date/time Site Signature Read (Circle one) 48 hrs / 72 hrs Signature

_____ _____ _____ _____

(Dose manufacturer _____ Lot# _____ Exp. Date _____)

---------- RESULTS OF TUBERCULIN TESTS ----------

This is to certify that a Tuberculin Test was done for _____

Initial test was done on _____ Result was _____ Nurse's Signature _____

Second Test was done on _____ Result was _____ Nurse's Signature_____

COMMENTS/ACTION TAKEN:

Infiniti Home Health Care, LLC

TB Screening

Employee: _____

Do you currently have any of the following that has lasted three (3) weeks or longer?

1.	Unexplained productive cough?	Yes	☐	No	☐
2.	Unexplained weight loss?	Yes	☐	No	☐
3.	Unexplained appetite loss?	Yes	☐	No	☐
4.	Unexplained fever?	Yes	☐	No	☐
5.	Night sweats?	Yes	☐	No	☐
6.	Shortness of breath?	Yes	☐	No	☐
7.	Chest pain?	Yes	☐	No	☐
8.	Increased fatigue?	Yes	☐	No	☐
9.	Bloody sputum?	Yes	☐	No	☐

Have you ever:

A.	Ever been told you have TB?	Yes	☐	No	☐
B.	Lived with anyone with TB?	Yes	☐	No	☐
C.	Had a positive TB skin test?	Yes	☐	No	☐
D.	Had a BCG vaccination?	Yes	☐	No	☐

E. Date of last negative PPD skin test result: ___/___/___

_____ _____

Employee Signature Date

EMPLOYER REVIEW:

I) If the employee answers yes to any question 1-9 document the objective reason for the symptom. If there is no known reason for the symptom lasting 3 weeks or longer the employee is to have a TB skin test.

II) If the employee answers yes to any question A-B, the employee is to have a TB skin test.

III) If the employee answers yes to question C the employee is to have either a chest x-ray or a physician statement noting the employee is free from communicable disease.

The following apply to this employee: (Circle one or more) I II III None

Administrative Review Completed by: _____ Date:_____