Occupational Medicine Center
of the Northwest - a division of Care Medical Group

4280 Meridian STE 120 ~ Bellingham, WA 98226 ~ Tel 360.734.4300 ~ Fax 360.734.2128
Hours: **Monday- Thursday** 8:00 AM – 8:00 PM
Friday 8:00 AM - 6:00 PM **Saturday** 9:00AM – 5 PM

TUBERCULOSIS (TB) SKIN TEST CONSENT

Company: _____

Name: _____
(Last) (First) (M.I.)

SSN: XXX – XX – _____ Birthdate: ____/____/____ Phone Number: ( ) ____- _____

Please indicate YES or NO to any of the following:	**YES**	**NO**
Have you ever had pain, ulceration or other strong reaction to a TB test?		
Have you ever had a positive skin test?		
If YES, were you evaluated for positive result?		

By signing this I give consent to the administration of a Tuberculin Skin Test:

*X*_____

For Clinic Use:

Reason for Test	**Type of Test**
❒ New employee, initial screening	❒ Single test (for those who have had a TB test within the past 6 months)
❒ Current employee, routine screening	❒ First Step of two steps (for patients who have not has a TB test within the past 12 months. **NOTE: Ask the Patient to return in 1-3 weeks for the second step.** ❒ Second step of two-step (for patients with documentation of a recent, completed first TB step test)

Date	**Time**	**Given By**	**Lot #**	**Arm**	**Date Read**	**Time**	**Read By**	**Result (mm)**
1st	am ___:___ pm			❒ Left ❒ Right		am ___:___ pm		
2nd	am ___:___ pm			❒ Left ❒ Right		am ___:___ pm		