GNR PUBLIC HEALTH

PREVENTIVE HEALTH CLINIC
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QFT AND TST CONSENT FORM

Instructions: Please read this form carefully. If you have any questions, speak with the TB provider before the test is performed.

Reason for Screening

☐ Medical Condition / Physician Referral ☐ School / Employment Requirement
☐ Immigration Process ☐ Other:_____

Patient Information

1. I understand that TB testing indicates whether I have been exposed to the bacteria that causes Tuberculosis.
   Initials: _____
2. **Country of Birth:** _____
3. **History of BCG Vaccine:** ☐ Yes ☐ No
4. **History of Positive PPD:** ☐ Yes ☐ No Result (mm): _____
   Chest X-ray: ☐ Normal ☐ Abnormal
5. **Prior Treatment for TB/LTBI:** ☐ Yes ☐ No
6. **Live Vaccines in the Past 30 Days:** ☐ Yes ☐ No
   If unsure, consult with staff.
   ☐ Yellow Fever ☐ MMR ☐ Varicella ☐ Zoster ☐ Nasal Flu ☐ Smallpox
7. **Medical Conditions** (e.g., HIV, Lupus, Psoriasis, RA, Pregnancy):
   ☐ Yes ☐ No If yes, list: _____
8. **Current Medications:** _____
9. **History of Incarceration:** ☐ Yes ☐ No
   If yes, facility/location: _____
10. **Employment Status:** ☐ Employed ☐ Unemployed
    If employed, list employer & location: _____

TB Symptom Screening

Check any that apply.

☐ Persistent Cough (≥ 3 weeks) ☐ Coughing Up Blood ☐ Fever
☐ Unexplained Weight Loss ☐ Night Sweats ☐ Fatigue / Weakness
☐ Chest Pain ☐ Shortness of Breath

Note: If you checked any symptoms, notify your provider immediately.

Patient Signature: _____ Date: _____

Staff Signature: _____ Patient Label: _____