

## TB Testing (Mantoux) Questionnaire

Name (please print): \_\_\_\_\_

Company: \_\_\_\_\_

SS No. \_\_\_\_\_

<input type="checkbox"/> New Employee	<input type="checkbox"/> Post Exposure
<input type="checkbox"/> Volunteer	<input type="checkbox"/> Annual

**Please answer the following questions by circling "Y" for Yes or "N" for No**

- |  |   |   |
|--|---|---|
| 1. Have you ever been tested for Tuberculosis before? .....                      | Y | N |
| 2. Were you ever told you tested positive for Tuberculosis? .....                | Y | N |
| 3. Are you pregnant?.....  | Y | N |
| 4. Have you been vaccinated for measles within the last five or six weeks? ..... | Y | N |
| (Measles vaccines are known to suppress the response)                            |   |   |
| 5. Have you recently had rubeola, influenza or mumps?.....                       | Y | N |
| 6. Are you currently receiving corticosteroids or immunosuppressive agents?..... | Y | N |
| 7. Have you taken BCG in the past eighteen months?.....                          | Y | N |

*I have read the information pertaining to the test I am about to receive. I have had a chance to ask questions and understand the answers.*

**CONSENT TO TEST** Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date Applied: \_\_\_\_\_ Site: L R Forearm Applied By: \_\_\_\_\_

Lot # \_\_\_\_\_ Expiration: \_\_\_\_\_ Manufacturer: \_\_\_\_\_

\*\* Instructions to have Mantoux read in 48-72 hours\*\*

**Test Results**

- Negative, 0mm induration
- Less than 5mm – Negative (refer to Occupational Medicine Physician, CRNP)
- 5mm-9mm – Doubtful (refer to Occupational Medicine Physician, CRNP)
- Equal to or greater than 10mm ( \_\_\_mm induration) (refer to Occupational Medicine Physician, CRNP)

**Read By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**\*\*If induration – Physician Signature:** \_\_\_\_\_

**Follow-up:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> None                   | <input type="checkbox"/> Return for 2 <sup>nd</sup> PPD on _____ | <input type="checkbox"/> Chest X-ray      |
| <input type="checkbox"/> Notified Health Bureau | <input type="checkbox"/> Instructions Provided                   | <input type="checkbox"/> No PPD in future |