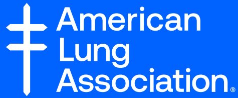

Tuberculosis Education

PATIENT CONSENT FOR EXAMINATION AND TREATMENT

I have been informed of the risks and benefits of receiving or refusing the procedure/treatment listed below. I have had the opportunity to ask questions, which were answered to my satisfaction. I request and consent that the procedure/treatment below be administered to me.

If you receive a TB Skin Test, you will be given a designated time to return to the health department within 48 to 72 hours. If the TB Skin Test is not read during that time, you will need to have another TB Skin Test applied.

Client's Name (printed) ______________________ Today's Date ______________________

Client's Signature ______________________ Nurse's Signature ______________________

Staff Use Only

PPD given at ____________ by ______________ Date _________ Date read __________ Result __________________________ mm

Date Given	Time Given	Site	Manufacturer	Lot #	Nurse Signature	Date Read	Time Read	Nurse Signature	Induration mm

Interpretation: ☐Reactive ☐CNon-reactive Date/Time______________________Consultation Date/Time __________________

Referrals/Comments ____

HEALTH PROFESSIONALS

This form was created by the American Lung Association in Indiana with the assistance of our Tuberculosis Education Task Force. For more information, visit us at Lung.org.

If you have medical-related TB questions, consult with your organization's policies or contact the Indiana Department of Health TB Program at 317-233-7434.