Health Canada Santé Canada

Tuberculin Skin Test Form

Client Demographic Information

* Indicates required information.

*Community Name:			
*Client's Name:			
	(Last Name, First Name, Middle Initial)	Alternate Name	
*Unique Identifier: (OHIP #)		*DOB: DD-MMM-YYYY	
Panorama Identifier:		*Gender: ☐ Male ☐ Female ☐ Undifferentiated	
Band Number:			

Tuberculin Screening Questions (to be completed by the Community Health Nurse- look in client chart for previous TSTs or TB history)

Please answer these screening questions by checking (√) where appropriate:

		YES	NO
1.	Have you/has your child had tuberculosis?	☐	☐
2.	Have you/has your child ever had a TB skin test **on their forearm** that caused a blister? (ie. allergic reaction)	☐	☐
3.	Have you/has your child ever had a TB skin test that caused a bump equal to or greater than 10 mm (size of a dime)?	☐	☐
4.	Have you/has your child had a live vaccine in the past 4 weeks? (measles, mumps, & rubella, varicella, yellow fever, herpes zoster or live attenuated influenza vaccine [ie. Flumist])?	☐	☐

If the client answers YES to ANY of the above 4 questions then they should NOT have a tuberculin skin test.

Consent for Tuberculin Skin Test (TST)

- o I have read or had explained to me information about the TST.
- o I have had the chance to ask questions, which were answered to my satisfaction.
- o I understand the risks and benefits associated with this test.
- o I am aware that personal health information collected on this form may be shared with another doctor or nurse if that is required for my care.
- o ***I consent to having the TST done and I am aware that I am required to return for reading of the test in 48-72 hours.***

*Form of Consent: ☐ Written ☐ Verbal	
*Relationship: ☐ Parent ☐ Client ☐ Substitute Decision-Maker	
Print Name of Person Giving Consent:	
Signature of Person Giving Consent:	Date:
Relationship:	

☐ ☐ ☐

Test Specification

*Date of Test: DD-MMM-YYYY		
*Time of Test:	____ ____: ____ ____	
Dose:	Route:	Site: ☐ Inner aspect of Rt forearm ☐ Inner aspect of Lt forearm ☐ Other-_____
Lot # Expiry Date:		

Please note 2 step Mantoux requires a physician's order

☐ Step 1 of 2 ☐ Step 2 of 2

Print Name of Provider:	Signature of Provider:

Test Results

*Date of Reading: DD-MMM-YYYY	
*Time of Reading:	____ ____: ____ ____
*Induration:	_____mm (mm measurement is mandatory for all results) ***For interpretation of results refer to page 75 of the Canadian TB Standards, 7th Edition, or as current***
*Check only one: ☐ Positive → **Fill out LTBI Report Form** ☐ Negative ☐ Not Read	
Follow Up: ☐ No follow up required ☐ Repeat TST | Inform TB/ CDC Nurse / Physician | Chest X-Ray	
Print Name of Provider:	Signature of Provider:

After reading and recording the test result, fax this page to the appropriate number below, and place this form in the client's chart.

Moose Factory, Southern, and Thunder Bay Zones	**FAX: 1-613-952-0177**
Sioux Lookout Zone	**FAX: 1-807-737-2141**

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Positive Tuberculin Skin Test Please answer these positive TST questions by checking (√) where appropriate: Write comments in the nursing notes section and sign and date.

- ☐ Cough
- ☐ Contact with someone who has had TB
- ☐ Fatigue
- ☐ Hemoptysis
- ☐ Fever
- ☐ Weight loss
- ☐ Night sweats

☐ Previous BCG vaccine — If YES, date of BCG vaccine: _____

☐ Any medical illness such as diabetes, HIV or other conditions that may cause immunosuppression (refer to pg. 127 of the Canadian TB Standards, 7th ed. or as current) — If YES, please list here: _____

Nursing Notes Check (√) each item when completed. Write comments in the nursing notes section and sign and date. Additional comments may be made in the client's chart.

WAIT 15 minutes after test

- ☐ Teaching re: signs & symptoms of reaction to the TST
- ☐ Teaching re: management of minor side effects
- ☐ Teaching re: serious reactions and how to manage
- ☐ Instructed client to return for reading in 48-72 hours
- Next appointment scheduled for: _____

Comments:

_____

_____

_____

_____

Nurse's Signature: **Date (DD/MMM/YYYY):**