MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

TUBERCULOSIS TESTING RECORD

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A. PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	SEX ☐ M ☐ F	WEIGHT (LBS)	AREA CODE - PHONE NUMBER	COUNTRY OF BIRTH - DATE ENTERED USA	ALIEN NUMBER

STREET ADDRESS	CITY	COUNTY	ZIP CODE	OCCUPATION	PLACE OF EMPLOYMENT	DATE OF HIV TEST RESULTS

RACE
☐ White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other ☐ Unknown

ETHNIC ORIGIN
☐ Hispanic ☐ Non-Hispanic

B. HISTORY OF TUBERCULIN TEST

HAVE YOU EVER HAD A BCG VACCINE? ☐ No ☐ Yes ☐ Unknown	DATE OF BCG VACCINE	HAVE YOU EVER HAD A TUBERCULIN TEST? ☐ Yes ☐ No ☐ Unknown	DATE OF PREVIOUS SKIN TEST	RESULTS OF PREVIOUS SKIN TEST (mm)

C. CURRENT TUBERCULIN PPD MANTOUX TEST(S), IGRA AND X-RAYS

HAD LIVE VACCINATIONS IN LAST FOUR WEEKS? ☐ No ☐ Yes (If yes, Hold TST for four weeks)	IGRA TEST DONE ☐ No ☐ Yes DATE	RESULTS ☐ Positive ☐ Negative ☐ Borderline ☐ Indeterminate

DATE/TIME PPD ADMINISTERED	MANUFACTURER	LOT NUMBER	ADMINISTRATOR'S SIGNATURE	DATE/TIME READ	RESULTS	READER'S SIGNATURE
DATE/TIME PPD ADMINISTERED	MANUFACTURER	LOT NUMBER	ADMINISTRATOR'S SIGNATURE	DATE/TIME READ	RESULTS	READER'S SIGNATURE

CHEST X-RAY DONE ☐ No ☐ Yes	DATE DONE	RESULTS ☐ Normal ☐ Abnormal	FINDINGS

D. HEALTH CARE PROVIDER

NAME/FACILITY	ADDRESS	PHONE NUMBER

REPORTED BY DATE OF REPORT:

NAME/FACILITY	ADDRESS	PHONE NUMBER

E. REASON FOR TESTING

☐ Contact to TB Case ☐ Employment ☐ Medically Referred ☐ Symptomatic ☐ Immigration ☐ Insurance ☐ Educational Enrollment ☐ Resident ☐ Other

EMPLOYER/RESIDENCE
☐ Long term Care Facility ☐ Department of Corrections ☐ Health Care Facility ☐ Substance Abuse Center ☐ School/Day Care ☐ County Jail ☐ Other

I consent to a tuberculin skin test (TST) for the above reason(s) I understand I am to have the skin test read in 48-72 hours by the designated reader/interpreter. If I do not return in 48-72 hours, I understand that I may need to have the TST readministered	CLIENT/GUARDIAN SIGNATURE	DATE

F. RISK FACTORS: (PLEASE CHECK ALL THAT APPLY)

☐ No Known Risk Factors ☐ Contact to TB Case ☐ High ☐ Medium ☐ Low ☐ Abnormal Chest X-Ray

☐ Alcoholic
☐ I.V. Drug User
☐ Homeless
☐ Migrant Worker
☐ Younger than 4 Years
☐ Underserved/Low Income
☐ Post-Gastrectomy
☐ Diabetes Mellitus
☐ Silicosis
☐ Skin Tests Converter Within 2 Years
☐ Prolonged Corticosteroid Therapy
☐ 10% or More Below Ideal Body Weight
☐ Provide Health Care Service
☐ Teaches High Risk Groups
☐ Immunosuppressed
☐ Foreign Born Where TB is Common
☐ Missionary/Military Where TB is Common
Country_____

Employee of:
☐ Department of Corrections ☐ Other Correctional Facility
☐ Long Term Care Facility ☐ Mental Health

Resident of:
☐ Department of Corrections ☐ Other Correctional Facility
☐ Long Term Care Facility ☐ Mental Health Facility

G. MEDICATION (DRUG/MG) - Provided by: ☐ Private Provider ☐ Health Dept.	FREQUENCY	DURATION IN MONTHS	START DATE
☐ INH___ ☐ B-6___ ☐ Rifampin___ ☐ INH/RPT___ ☐ Other____	☐ Daily ☐ Weekly ☐ 2 or 3 times weekly by DOT		

REASON WHY TREATMENT NOT STARTED: ☐ Patient Declined Therapy ☐ Physician Did Not Order ☐ Medical Contraindication ☐ Previously treated (documentation Provided)	LATENT TB INFECTION (LTBI) ☐ No ☐ Yes	RESOLUTION ☐ Close ☐ Open

COMMENTS:

PREVENTIVE TREATMENT MONITORING **CONTINUATION**

PATIENT'S NAME				DATE OF BIRTH								
ENCOUNTER DATE:												
ALLERGIES ☐ NKA ☐ Yes List:												
MEDICATIONS	**mg**											
B-6												
INH												
Rifampin												
INH/RPT												
Other												
ADVERSE EFFECTS		**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**	**ADVERSE EFFECTS**
Fatigue, Weakness													
Fever, Chills													
Loss of Appetite													
Nausea													
Vomiting													
Jaundice													
Dark Brown Urine													
Rash													
Itching													
Joint Pain													
Numbness/Tingling													
Abdominal Discomfort													
Other													
OTHER MEDICATIONS													
LIVER ENZYME COLLECTION DATA		**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N	**LFTs** ☐ Y ☐ N
ALT Results		ALT	ALT	ALT	ALT	ALT	ALT	ALT	ALT	ALT	ALT	ALT	ALT
AST Results		AST	AST	AST	AST	AST	AST	AST	AST	AST	AST	AST	AST
Next Encounter Date													
COMMENTS													
EVALUATOR NAME/SIGNATURE/TITLE													

Note: CDC now recommends shorter courses of treatment for LTBI

COMPLETION OF TREATMENT

TREATMENT STOPPED (MONTH/DAY/YEAR)

TREATMENT COMPLETED (MONTH/DAY/YEAR)

REASON TREATMENT STOPPED

☐ Completed Treatment
☐ Death
☐ Client Moved (Follow-Up Unknown)
☐ Client Chose to Stop
☐ Client is Lost to Follow-Up
☐ Provider Decision to Stop
☐ Physician Declined Preventive Therapy
☐ Active TB Developed
☐ Adverse Effect of Medicine
☐ No Therapy Needed
☐ Patient Refuses Preventive Therapy

DATE

HEALTH CARE PROVIDER SIGNATURE/NURSE SIGNATURE