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CalvertHealthMedicine.org

TUBERCULOSIS SKIN TEST (TST) SCREENING FORM

Name: _____ () Employee () Medical Staff

I agree to have 0.1 mL Mantoux tuberculin skin test (TST) administered intradermally (under the skin) in my forearm. I understand that I must return in 48 – 72 hours to have each test read, or I will need to have the test repeated.

Signature: _____ Date: _____

Reason for Test:

Annual Screening _____
Possible Exposure _____
Other (please explain) _____

Have you ever had any of the following?

- ____ Positive TB skin test
- ____ Taken medication for tuberculosis
- ____ Been told you had tuberculosis germ in your body
- ____ Been exposed to anyone with active tuberculosis disease

If history of contact or previous positive TB skin test, please give details and document any signs and symptoms of TB disease.

Date of 1st TST _____ Site: _____
Nurse administering TST: _____
PPD Manufacturer: _____ Lot Number: _____ Expiration date: _____
Date of Reading: _____
Results of Reading: _____
Nurse Reading Results: _____ mm's

Date of 2nd TST _____ Site: _____
Nurse administering TST: _____
PPD Manufacturer: _____ Lot Number: _____ Expiration date: _____
Date of Reading: _____
Results of Reading: _____
Nurse Reading Results: _____ mm's

Refer to Annual TB Screening Policy for TST Interpretation Guidelines

Effective:

