Mantoux Tuberculin Skin Test (TST) – Screening & Consent Form

Name: ____________________DOB__________________Date________________

(*Check* ***Yes*** *or* ***No*** *for each question. All questions must be answered before administering the TST.*)

#	Question	Yes	No	Notes (if Yes)
1	Have you ever received the Bacille Calmette-Guérin (BCG) vaccine?	☐	☐	______________________
2	Have you ever had a *positive* TB skin test or IGRA blood test?	☐	☐	______________________
3	Have you ever been treated for latent or active tuberculosis?	☐	☐	______________________
4	Are you currently experiencing any of the following: persistent cough (>3 weeks), coughing up blood, fever, night sweats, unexplained weight loss, or fatigue?	☐	☐	______________________
5	Have you received any live-virus vaccine (e.g., MMR, varicella, yellow fever) in the past 4 weeks?	☐	☐	______________________
6	Are you pregnant, planning pregnancy, or breastfeeding?	☐	☐	______________________
7	Do you have a known allergy to latex, phenol, or components of the tuberculin product?	☐	☐	______________________
8	Are you currently taking immunosuppressive medication (e.g., ≥15 mg/day prednisone for ≥1 month, TNF-α inhibitors, chemotherapy)?	☐	☐	______________________
9	Do you have a medical condition that weakens the immune system (e.g., HIV/AIDS, leukemia, lymphoma, organ transplant, chronic renal failure)?	☐	☐	______________________
10	Have you ever had a severe local or systemic reaction to a previous TST?	☐	☐	______________________

Section 4 – Patient Acknowledgment & Consent

I have reviewed the information provided and my questions have been answered. I understand the purpose and possible side effects (localized redness, itching, swelling, bruising, rare allergic reaction) of the Mantoux tuberculin skin test. I agree to return **48–72 hours** after placement (and again for a second test if two-step selected) for test reading. I consent to the administration of the TST as indicated above.

Patient Signature______________________________Date______________________5A. First TST Placement

Parent Signature ______________________________ Date _______________________

All TB Tests are placed in the Left FA unless contraindicated.

Step 1: Date:_____________ MFR_____________Lot:__________ Exp:_________________ NR Reactive____MM

Tech:___________________ Time Placed:________________ Date/Time Read______________________________

Step 2: Date:_____________ MFR_____________Lot:__________ Exp:_________________ NR Reactive____MM

Can be placed 7-21 days after Step 1.

Tech:___________________ Time Placed:________________ Date/Time Read______________________________

Clinician Verified Reactive Test__________

Follow-Up for Reactive Tests

Chest X-ray Ordered? ( ) Yes ( ) No

Referral to Metro TB Clinic? ( ) Yes ( ) No

Reference: CDC & USPHS recommendations for Mantoux TST (CDC Core Curriculum on Tuberculosis 7th Ed., 2023

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