



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 <i>positive</i> 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)

5350 Transportation Blvd., Garfield Heights, OH 44125

Phone: 216-328-240

Fax: 216-642-7945