ASSURED NURSING
18725 N. Union St.
Westfield, IN 46074
Office: 317-862-8141
Fax: 317-862-8143

Tuberculosis Skin Test Form

Date	Employees Name	DOB	Phone

Full Address	Email

Your previous Tuberculosis Skin test was ☐ Negative ☐ Positive

Have you ever been treated for tuberculosis?	☐ Yes	☐ No
Have you ever had close contact with someone who had Tuberculosis?	☐ Yes	☐ No

DO YOU HAVE ANY OF THE FOLLOWING

A cough that has lasted more than 3 weeks?	☐ Yes	☐ No
Night sweats?	☐ Yes	☐ No
Persistent fever?	☐ Yes	☐ No
Unexplained weight loss?	☐ Yes	☐ No
A cough that produces bloody sputum/phlegm?	☐ Yes	☐ No

TEST ADMINISTERED

☐ Left forearm ☐ Right forearm	Date (*month, day, year*): Time: ☐ AM ☐ PM	Signature of Health Care Provider

TEST READ **DISPOSITION INITIAL OR ROUTINE SKIN TEST RESULTS**

Millimeters of induration	Date read (*month, day, year*): Time: ☐ AM ☐ PM	☐ Negative ☐ Without symptoms ☐ With symptoms (*employees should consult their primary care provider on their own time*) ☐ Positive with or without symptoms

Signature of Health Care Provider

For new employees Two-step testing will be conducted on all individuals at their initial or baseline screening, with the second TB skin testing administered at least seven (7) days but no more than thirty (30) days after the first test.

TEST ADMINISTERED

☐ Left forearm ☐ Right forearm	Date (*month, day, year*): Time: ☐ AM ☐ PM	Signature of Health Care Provider

TEST READ **DISPOSITION SECOND STEP**

Millimeters of induration	Date read (*month, day, year*): Time: ☐ AM ☐ PM	☐ Negative ☐ Positive (*advise employee that he/she is positive and should not receive additional TB skin tests*)

Signature of Health Care Provider	Providers Printed Name

Providers Address	Providers Phone