MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

TUBERCULOSIS TESTING RECORD

A. PATIENT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL) | PHONE NUMBER

INMATE NUMBER | STUDENT ID NUMBER | SOCIAL SECURITY NUMBER

ADDRESS/STREET | CITY | ZIP CODE

COUNTY | DATE OF BIRTH | WEIGHT | SEX ☐ Male ☐ Female

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

ETHNIC ORIGIN
☐ Hispanic ☐ Non-Hispanic

OCCUPATION | ALIEN NUMBER

PLACE OF EMPLOYMENT | DCN NUMBER

B. HISTORY OF TUBERCULIN TEST

HAVE YOU EVER HAD A BCG **VACCINE**?
☐ No ☐ Yes ☐ Unknown

HAVE YOU EVER HAD A TUBERCULIN TEST?
☐ No ☐ Yes ☐ Unknown

WHEN/DATE

RESULTS IN **MM** OF PREVIOUS SKIN TEST | TYPE OF TEST

C. CURRENT TUBERCULIN PPD MANTOUX TEST(S)/X-RAYS

DATE/TIME ADMINISTERED | MANUFACTURER | DATE/TIME ADMINISTERED | MANUFACTURER

DATE/TIME READ | LOT NUMBER | DATE/TIME READ | LOT NUMBER

RESULTS IN MM | ADMIN. SIGNATURE | RESULTS IN MM | ADMIN. SIGNATURE

IGRA TEST DONE
☐ No ☐ Yes
(IGRA=T Spot or Quantiferon)

DATE/TIME

RESULTS
☐ Positive ☐ Negative
☐ Borderline ☐ Indeterminate

CHEST X-RAY DONE
☐ No ☐ Yes

DATE DONE

RESULTS
☐ Normal ☐ Abnormal

FINDINGS

D. HEALTH CARE PROVIDER

NAME/FACILITY

ADDRESS | PHONE NUMBER

REPORTED BY

NAME/FACILITY | PHONE NUMBER

ADDRESS | REPORT DATE

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 re-administered.

CLIENT'S/GUARDIAN SIGNATURE | **DATE**

F. RISK FACTORS

PLEASE CHECK ALL THAT APPLY

☐ Contact to TB Case – ☐ High ☐ Medium ☐ Low
☐ Abnormal Chest X-Ray
☐ Alcoholic
☐ Younger Than 4 Years of Age
☐ Underserved/Low Income
☐ Post-Gastrectomy
☐ Prolonged Corticosteroid Therapy
☐ 10% or More Below Ideal Body Weight
☐ Skin Test Converter With 2 Years
☐ I.V. Drug User
☐ Homeless
☐ Migrant Worker
☐ Diabetes Mellitus
☐ Silicosis
☐ Provide Health Care Service
☐ Teaches High Risk Groups
☐ No Known Risk Factors
☐ Immunosuppressed
☐ Foreign Born Where TB is Common
☐ Employee of Dept. of Corrections
☐ Employee of other Correctional Facility
☐ Employee of Long Term Care Facility
☐ Employee of Mental Health Facility
☐ Resident of Dept. of Corrections
☐ Resident of Other Correctional Facility
☐ Resident of Long Term Care Facility
☐ Resident of Mental Health Facility

G. TREATMENT/RECOMMENDATIONS

STATUS
☐ Close ☐ Open

LATENT TB INFECTION (LTBI)
☐ No ☐ Yes

MEDICATION PROVIDED BY
☐ Private Provider ☐ Health Dept.

H. MEDICATION

DRUG/MG
☐ INH _____ ☐ B-6 _____ ☐ Rifampin _____ ☐ INH/RPT_____ ☐ Other_____

FREQUENCY
☐ Daily ☐ Weekly ☐ 2 or 3 Times Weekly by DOT

DURATION (IN MONTHS) | START DATE

REASON TREATMENT NOT STARTED

☐ Patient Refuses Therapy ☐ Physician Did Not Order ☐ Medical Contraindication
☐ Previously Treated (Documentation Provided)

COMMENTS

PREVENTIVE TREATMENT MONITORING **CONTINUATION**

PATIENT'S NAME	DATE OF BIRTH	Note: **9** months of INH treatment is recommended for all infected persons

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												

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
☐ Active TB Developed
☐ Adverse Effect of Medicine
☐ No Therapy Needed
☐ Patient Refuses Preventive Therapy
☐ Client is Lost to Follow-Up
☐ Provider Decision to Stop
☐ Physician Declined Preventive Therapy

DATE

HEALTH CARE PROVIDER SIGNATURE