Central Coast Med Plus

Dignity Health
Pacific Central Coast
Health Centers

Phone: (805) 614-9000 • Fax (805) 614-9048

Tuberculosis Screening

☐ PPD with Physical ☐ PPD Only ☐ Private ☐ Employer_____

Social Sec.#:_____

Name: Last	First	MI	Date of Birth	Sex:

Home Address:	ZIP Code:	Phone Home: Cell:

Previous PPD Date: _____ ☐ Positive ☐ Negative	Previous QFT Date / Result	INH Treatment: ☐ Yes ☐ No

HISTORY:

In the last 12 months, have you had any of the symptoms listed below that lasted for more than 3 weeks at a time?

	No	Yes		No	Yes
Excessive sweating at night	____	____	Excessive weight loss	____	____
Persistent coughing	____	____	Excessive fatigue	____	____
Coughing up blood	____	____	Persistent fever	____	____

CONSENT:

- I hereby request and authorize the above medical center to provide a TB screening test and / or chest x-ray as guided by the current standard of medical care.
- I further agree to return to have test read within the required time of 48 to 72 hours.

_____ _____

Signature Date

TEST: ***This Section for Medical Center Use Only***

Lot #:	Exp. Date:	Location: LF RF
Date Placed:	Placed by Name:	
Date Read:	Read by Name:	**Name & Phone # of Off Site Facility:
READING: ____**mm Induration**	_____**NEGATIVE**	_____***POSITIVE**

* If the "READING" is POSIT VIE the patient is to receive a single view chest X-ray.
** Results being read at an alternative facility are to have completed form faxed to **805-614-9048.**