Southwest Utah Public Health Department – TB Intake Form

All information is strictly confidential

Today's Date: _____

CLIENT INFORMATION (PLEASE PRINT)

Name: _____ Mother's Maiden Name: _____
Last First Middle

Address: _____
Street/P.O. Box City State Zip Code

Telephone: ( )_____ - _____ ☐ Home ☐ Cell ☐ Message ☐ Work

Telephone: ( )_____ - _____ ☐ Home ☐ Cell ☐ Message ☐ Work

Email: _____

Birth Date: _____ / _____ / _____ Age: _____ Gender: ☐ Male ☐ Female
MO DY YR

Race: ☐ White ☐ Black ☐ Asian ☐ Indian/American Native ☐ Native Hawaiian/Pacific Islander ☐ Other

Are you Hispanic/Latino? ☐ Yes ☐ No

Medicaid: ☐ Yes ☐ No Self Pay: ☐ Yes or Organization to bill for this service_____

Has the individual received any vaccinations is the past 4 weeks? ☐ Yes ☐ No

Has the individual ever received BCG (tuberculosis) vaccine? ☐ Yes ☐ No

Have you ever been diagnosed with latent or active tuberculosis? ☐ Yes ☐ No

Have you ever had treatment for tuberculosis? ☐ Yes ☐ No

Date of last TB test: _____ Results: _____

CONSENT FOR TREATMENT AND PRIVACY NOTICE

I certify that the information I have provided is true and accurate. I understand the TB test will need to be "read" within 48-72 hours. I agree that this information may be shared with schools, daycare centers, healthcare providers and others when deemed medically necessary. I HEREBY RELEASE SOUTHWEST UTAH PUBLIC HEALTH DEPARTMENT, AND ITS EMPLOYEES, FROM ALL CLAIMS ARISING FROM SUCH TB TESTING. We are required to inform you of our privacy practices for the information we collect and keep about you. I have been offered a copy of the Health Department's Notice of Privacy Practices and have had an opportunity to ask questions about how my information may be used.

Signature: _____ Date: _____

Relationship to Client: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other _____

For Health Department Use

☐ PPD

Date Placed: _____ Time: _____ JHP Aplisol PPD 5 TU/0.1ml, Lot #: _____ **Site: LFA RFA** Nurse: _____

Date Read: _____ Time: _____ mm Results: _____ Person Reading Results: _____

Referred to: _____

☐ TB Screening Questionnaire

Nurse: _____

☐ QFT Referral

Nurse: _____

Rev: 06/2021 smc