

**TB CONSENT AND RECORD**

CLINIC SITE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Complete all highlighted sections**

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| **PATIENT AND INSURANCE/PAYMENT INFORMATION**NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX (M)\_\_\_\_\_\_\_\_\_(F)\_\_\_\_\_\_\_\_\_ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT \_\_\_\_\_\_\_\_\_\_\_CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE (1)­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LAST 4 DIGITS OF SOCIAL SECURITY NUMBER\_\_\_\_\_\_\_\_\_INSURANCE COMPANY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLAN TYPE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SECONDARY INSURANCE COMPANY NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLAN TYPE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PATIENT SCREENING QUESTIONS** * **Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Have you received any live vaccines (such as MMR, Varicella, or Zostavax vaccines) in the past 4 weeks: Yes / No**
* **Prior BCG Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TESTING PROCEDURE**1. **Test will be read in 48-72 hours from when it was applied.**2. Do not scratch site of test. 3. You may experience some irritation or swelling following the test, do not attempt to scratch or apply ice pack as this may affect the outcome of the test. If the swelling or discomfort is excessive please contact your primary care provider. |

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| **PATIENT CONSENT*** I have had a chance to ask questions and they were answered to my satisfaction. I believe I understand the benefits and the risks and ask that the vaccine or injection be given to me or to the person named for whom I am authorized to make this request.
* I have received a copy of the Notice of Privacy Practices.
* I have read and answered the questions above. I hereby consent to have a PPD test - which screens for Tuberculosis, be done on me and **I shall return within 48 hours to the Health Fair to have the test read**. By signing below, I release American HealthCare LLC, Pathways to SmartCare, and all other organizations associated with this screening, parent, and affiliated companies, successors, and assigns, officers, directors, staff and employees from any and all liability arising from my participation in in this screening as described above.
* Financial Responsibility:

By my signature below, I acknowledge that I have received the vaccine as indicated and I authorize my provider to bill and collect from my insurance for the vaccine and related administration fees. I understand that this authorization does not release me from any financial responsibilities (co-payments or deductibles) required under my plan. I have been notified that my insurance may deny payment entirely or partially for the vaccine or injection. If my insurance denies payment for the entire amount or for a partial amount, I agree to be personally and fully responsible for payment.Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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# Tuberculosis Skin Test (TST) Consent Form

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(To Be Completed By TB Administrator)**

***Codes for TB***

\_\_\_\_\_\_\_\_\_ 86580 TB

***Codes for Administration of TB***

\_\_\_\_\_\_\_\_\_ 99211 Administration

**Below is for Office use only:**

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| **Site of PPD Test: Dose Given:** 0.1 cc |
| **Date of PPD Test: Time of PPD Placement:**  |
| **Lot # of PPD: Expiration Date:**  |
| **Administered by:**  |
| **MUST RETURN WITHIN 48-72 HOURS FOR TB READ** |
| **Result: Negative/ Positive \_\_\_\_\_\_\_\_\_\_\_\_(mm)** |
| **Date Test was read: Time Test was read:**  |
| **Test Read by:**  |

# (rev. 2/11/2020)