



TUBERCULOSIS SCREENING FOR EMPLOYEES WITH PREVIOUSLY NEGATIVE SKIN TEST

State Form 45900 (R / 2-05)

INDIANA DEPARTMENT OF CORRECTION

CONFIDENTIAL RECORD

Your previous Tuberculosis Skin test was		
<input type="checkbox"/> Negative	<input type="checkbox"/> Positive (if checked use State Form 45871)	
Have you ever been treated for tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had close contact with someone who had Tuberculosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any of the following:		
A cough that has lasted more than 3 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Night sweats?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Persistent fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unexplained weight loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A cough that produces bloody sputum/phlegm?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have reviewed the above documentation and agree that it is accurate. _____ (employee's initials)		

EMPLOYEES:	
<p>I consent to receive a tuberculosis skin test. I certify that I am not, to my knowledge, already sensitive to tuberculosis protein and understand that a positive reaction to this test can result in itching, local swelling, irritation, or local blistering. I further understand that refusal to participate may subject me to disciplinary action up to and including dismissal. The test is a two part test and requires that I return on _____ to have it read.</p> <p>Pregnant employees: the use of this test during pregnancy has not been specifically studied. However, the United States Centers for Disease Control and Prevention advise that it can safely be provided to pregnant women. It is recommended that pregnant employees be tested. If you are pregnant and do not wish to be tested, you will need to provide a statement from the doctor managing your pregnancy asking that your test be delayed until after your pregnancy is over.</p>	
<input type="checkbox"/> I have read and understand the above and consent to be tested.	
Signature of employee	Date (month, day, year)
<input type="checkbox"/> I have read and understand the above. I am pregnant, do not wish to be tested, and will provide a statement from my doctor requesting that this test be deferred. I understand that I must provide this statement within one (1) week or be subjected to disciplinary action.	
<input type="checkbox"/> I have read and understand the above and decline to be tested even though that may subject me to disciplinary action up to and including dismissal.	
Signature of employee	Date (month, day, year)
Signature of witness	Date (month, day, year)

TEST ADMINISTERED		
<input type="checkbox"/> Left forearm <input type="checkbox"/> Right forearm	Date (<i>month, day, year</i>): Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Signature of Health Care Provider
TEST READ DISPOSITION INITIAL OR ROUTINE SKIN TEST RESULTS		
Millimeters of induration	Date read (<i>month, day, year</i>): Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Negative <input type="checkbox"/> Without symptoms <input type="checkbox"/> With symptoms (<i>employees should consult their primary care provider on their own time</i>) <input type="checkbox"/> Positive with or without symptoms (<i>Complete State Form 43926</i>)
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		
<input type="checkbox"/> Left forearm <input type="checkbox"/> Right forearm	Date (<i>month, day, year</i>): Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Signature of Health Care Provider
TEST READ DISPOSITION SECOND STEP		
Millimeters of induration	Date read (<i>month, day, year</i>): Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	<input type="checkbox"/> Negative <input type="checkbox"/> Positive (<i>advise employee that he/she is positive and should not receive additional TB skin tests</i>)
Signature of Health Care Provider		
Name of employee		
Social Security number (<i>voluntary - for identification purposes only</i>)		