WYNN FAMILY MEDICINE, PLLC
8316 ARLINGTON BLVD., #234
FAIRFAX, VA 22031
TEL 703-560-0300 FAX 703-560-8679

PPD CONSENT FORM

PATIENT NAME:_____

The physician has ordered a PPD test for you. The test will indicate if you have been exposed to the bacteria that causes tuberculosis.

You must return in 48 to 72 hours (2 to 3 days) to have the test read by a member of our staff. If you do not return, the test will have to be repeated in one (1) month.

Please answer the following questions by circling YES or NO:

1. **Have you had a tuberculin (TB) test in the past six (6) months?** **YES NO**
2. **Have you ever had a positive result on a TB test?** **YES NO**
3. **Have you ever had a BCG* immunization?** **YES NO**
4. **Have you ever had an allergic reaction to a TB test?** **YES NO**

_____ _____
PATIENT SIGNATURE **DATE**

*A BCG vaccine is a vaccine against tuberculosis given in several countries. You may have had this vaccine if you grew up outside of the United States. It is **not** given in the U.S.

FOR STAFF USE ONLY

Date of Placement:_____ PPD Lot #_____ Exp. Date_____

Area of placement (circle) **Right forearm** **Left forearm**

MA Signature_____

Date of Reading_____

Result: Negative (0-9mm) Positive (10mm or more) If positive, size____mm

MA Signature_____