



Health Department

Tuberculosis Skin Test

Riley County Health Department
 2030 Tecumseh Rd
 Manhattan, Kansas 66502
 Phone: 785-776-4779
 Fax: 785-565-6566
 www.rileycountyks.gov/health

DEMOGRAPHICS

Patient's First Name:		Middle Name:		Last Name:		Maiden Name/Alias:	
Birth Date:	Age:	Phone Number:	Social Security Number:		Primary Language:		
Ethnicity: Hispanic <input type="checkbox"/> Yes <input type="checkbox"/> No		Race: (Select one or more.) <input type="checkbox"/> Asian/Pacific Islander/Other <input type="checkbox"/> Black or African American <input type="checkbox"/> Caucasian or White <input type="checkbox"/> Hawaiian <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Unknown or Other					
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Apt #:	City:	State:	County:	Zip Code:	

BILLING

Primary Insurance Carrier
 Insurance Co. Name _____ ID#: _____ Group# _____
 Policy Holder (Name): _____ Policy Holder's Birthdate: _____
 Patients relationship to policy holder (child, spouse, self) _____

By my signature below, I authorize the Riley County Health Department to bill any of the medical payers as indicated above and provide necessary information to process claims. I authorize payment of medical benefits to the Riley County Health Department for services rendered and I understand I will be responsible for payment of charged deemed "uncovered" by my health insurance. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Riley County Health Department and payment is not made by KanCare or your Health Insurance, you may be responsible for the charges. You may also be responsible for charged if you fail to inform the Health Department of Insurance coverage in a timely manner. The undersigned has read the above authorization and understands the same. I certify that the information provided on this page is true and correct to the best of my knowledge.

SIGNATURE _____ **DATE** _____

PRIVACY PRACTICES

All records of services rendered are considered confidential. I acknowledge that I have been offered a copy of the Riley County Health Department's Notice of Privacy Practices with the effective date of September 2013.

SIGNATURE _____ **DATE** _____

TUBERCULOSIS SKIN TEST QUESTIONNAIRE

1. Have you ever had Tuberculosis? If so, when were you diagnosed?	Yes	No
2. Have you ever had a positive reaction to a TB skin test or TB blood test? If so, when?	Yes	No
3. Have you had a chest X-Ray to diagnose Tuberculosis? If so, when and where...	Yes	No
4. Have you ever taken medication for tuberculosis? If so, when?	Yes	No
5. Do you have any allergies to medication, food, TB skin test, or latex? If so, list and describe...	Yes	No
6. Have you ever been immunized against TB with BCG or other serum?	Yes	No
7. Have you had any type of vaccine within the past 4 weeks? If so, what vaccine(s)?	Yes	No
8. Have you taken steroids of any kind during the last 4 weeks? If so, list...	Yes	No
9. Have you had a known exposure to TB since your last TB test?	Yes	No
10. Has any member of your family had tuberculosis? If yes, relation...	Yes	No
11. What is your occupation? (please write in) _____		

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS?

12. A persistent cough for longer than 2 weeks?	Yes	No
13. Coughing up blood?	Yes	No
14. Profuse night sweats?	Yes	No
15. Recurring, dull, tightness, or aching pain in chest?	Yes	No
16. Loss of appetite?	Yes	No
17. Unexplained weight loss?	Yes	No
18. Chills and/or fever?	Yes	No
19. Have you ever lived in or visited another country? If so list...	Yes	No

TUBERCULOSIS SKIN TEST CONSENT

I have received information about the TB skin test. I had a chance to ask questions which were answered to my satisfaction. I agree to return in 48-72 hours to have the test read. I understand the risks and benefits of the TB skin test and request the test be given to me or to the person named above for whom I am parent or legal guardian of and authorized to make medical decisions for.

SIGNATURE _____ **DATE** _____

NURSE DOCUMENTATION

Lot #:	Exp:	Site: LT RT	Time:	Signature:
---------------	-------------	--------------------	--------------	-------------------