

**Virginia Department of Health
CONTACT REGISTRATION FORM
(PLEASE PRINT)**

Referrals:

 Pregnant? Y N
 Action Taken: _____

Today's Date: _____ **Site:** _____

CLIENT SECTION

Last _____ First _____ Middle _____

Birth Date _____ SSN _____

Home Address _____ Apt # _____

City, State, Zip _____

Phone: (_____) _____ Cell Phone: (_____) _____

Race _____ Sex _____ Marital status _____ Physician/Provider: _____

Country of Origin: _____ Provider #: (_____) _____

Parent/Guardian: _____ Other #: (_____) _____

Health Dept. Use Only

Web Vision ID#: _____ **Health Department Use Only** **City/County of Residence:** _____

Contact Association

 _____ Other _____

Prior Mantoux TST? ___Yes ___No

If yes, Date: _____ Induration: _____ mm

Location where TST was done: _____

Prior Tx: ___No ___Yes → ___ Disease ___LTBI

Meds Taken: _____

TB Symptoms (Check all that apply)

- ___ None
- ___ Cough ≥ 3 weeks
- ___ Productive
- ___ Hemoptysis
- ___ Fever, unexplained
- ___ Unexplained weight loss
- ___ Poor appetite
- ___ Night Sweats
- ___ Fatigue

→ These items should be evaluated in context.

TST #1 Arm: ___Left ___Right

Date Given: _____ Time: _____

Date Read: _____ Time: _____

Result: _____ mm ___Positive ___Negative

Signature: _____ POS# _____

TST #2 Arm: ___Left ___Right

Date Given: _____ Time: _____

Date Read: _____ Time: _____

Result: _____ mm ___Positive ___Negative

Signature: _____ POS# _____

IGRA #1 Type: ___QFT-G-IT ___T-Spot

Date drawn: _____

Result: ___Pos ___Neg ___Borderline/Indeterminate

Signature: _____ POS# _____

IGRA #2 Type: ___QFT-G-IT ___T-Spot

Date drawn: _____

Result: ___Pos ___Neg ___Borderline/Indeterminate

Signature: _____ POS# _____

Additional Individual Risk for Infection (Check all that apply)

- ___ Lived - High Prevalence Country
- ___ List Country: _____
- ___ Resident/Employee of a congregate setting
- ___ Medically underserved
- ___ Uses illegal drugs
- ___ Homeless within the last 2 years _____
- ___ Past known contact; Where/When: _____

Individual Risk for Progression to Disease (Check all that apply)

- ___ HIV infection
- ___ Medical conditions that increase risk: (diabetes, ESRD, Cancer, 10% below ideal weight, etc.)
- ___ History of inadequate TB treatment
- ___ Immunosuppressive therapy: (steroids, cancer treatment, include treatment for Rheumatoid Arthritis such as Remicade, Humira, etc.)

Allergies: _____

Notes: _____

- I hereby authorize the doctors, nurses, or nurse practitioners of the Virginia Department of Health to administer the Tuberculin Skin Test (PPD) or draw blood for an IGRA test from me or my child named above.
- I agree that the results of this test may be shared with other health care providers.
- The Deemed Consent for blood borne diseases has been explained to me and I understand it.
- I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.
- I understand that:
 - this information will be used by health care providers for care and for statistical purposes only.
 - this information will be kept confidential.
 - medical records must be kept at a minimum of 10 years after my last visit, 5 years after death; for minor children, 5 years after the age of 18, or 10 years after the last visit, whichever is greater.

X _____ Date: _____