Virginia Department of Health
CONTACT REGISTRATION FORM
(PLEASE PRINT)

Referrals:
_____
_____
Pregnant? Y N
Action Taken:_____
_____
_____
Health Dept. Use Only

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 #: (_____) _____

***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: _____

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# _____

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.

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
___ Immunosupressive 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 (TST) or draw blood for an Interferon Gamma Release Assay (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 for 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: _____

د ویرجینیا د روغتیا وزارت - د توبرکلین د پوستکي ازموینې د ترسره کولو لپاره رضایتنامه

Virginia Department of Health - Consent for Administration of the Tuberculin Skin Test-Pashto

زه په دې سره د ویرجینیا د روغتیا وزارت ډاکټران، نرسانې، یا نرس پریکټیشنران واک ورکوم چې زما یا پورته نومول شوي ماشوم څخه د توبرکلین د پوستکي ازموینه (TST) ترسره کړي یا د انټرفیرون ګاما ریلیز اسای (IGRA) لپاره وینه واخلي.

زه موافق یم چې د دې ازموینې پایلې د نورو روغتیایي خدماتو چمتو کونکو سره شریکه شي.

زه پوهیږم او ما ته د وینې له لارې انتقالیدونکو ناروغیو لپاره د مفروضې رضایت توضیح شوی دی.

زه تائید کوم چې ما د ویرجینیا د روغتیا وزارت د محرمیت د کړنو خبرتیا ترلاسه کړې ده.

زه پوهیږم چې:

- دا معلومات به یوازې د روغتیایي خدماتو چمتو کونکو لخوا د درملنې او احصایوي موخو لپاره وکارول شي.
- دا معلومات به محرم وساتل شي.
- طبي ریکارډونه باید لږ تر لږه د ما وروستي لیدنې څخه وروسته 10 کاله وساتل شي، د وفات وروسته 5 کاله؛ د نابالغو ماشومانو لپاره، د 18 کلنۍ څخه وروسته 5 کاله یا د وروستي لیدنې څخه 10 کاله، کوم چې زیات وي.

لاسلیک_____نیټه: _____