TRINITY
URGENT CARE

A SENSIBLE ALTERNATIVE TO THE EMERGENCY ROOM
OPEN 9AM TO 9 PM
365 DAYS A YEARS

Tuberculosis Questionnaire

1. Have you ever had a positive TB test? ☐ YES ☐ NO
2. Have you ever received a BCG immunization? ☐ YES ☐ NO
3. Have you ever been treated for TB? (I N H Drug Therapy) ☐ YES ☐ NO
4. Have you ever had any of the following symptoms in the past two weeks: fever, night sweats, weight loss, chronic cough, cough up blood? ☐ YES ☐ NO

I understand that I must return to Trinity Urgent Care to have this test read between 48 and 72 hours from the time of the test. I understand that if I fail to return within the specified period of time, the test will be considered invalid and will have to be repeated at my expense.

_____ D.O.B:_____
(Print Name)

_____ Phone#_____
Patient Signature

_____ Date: _____
Physician Signature (ordered by)

RETURN AFTER:

OR BEFORE:

Testing Date: _____ MA Initials: _____ Site: _____

Time of Test: _____ Lot # _____ Exp. _____

Date Read: _____ Read By: _____

Time Read: _____ Results:_____

Xray Date: _____ Xray Results:_____

_____

Physician Signature (results)