Fair Lakes Urgent Care Center

12713 Shops Lane Fairfax, VA 22033 Tel: (703) 222-3555 http://www.flucc.com

PPD CONSENT FORM

Patient Name_____ Today's Date_____

Sex_____ Date of Birth_____Age_____Social Security #_____Tel_____

Address_____City_____State_____Zip_____

Allergies_____Prior BCG Vaccine_____Last Menstrual Period_____

Have you received any live vaccines (such as MMR, Varicella vaccine, etc) in the past 4 weeks? Yes / No

PPD Instructions

1. Do not scratch site of test.
2. Test will be read in 48-72 hours from when it was applied and you will need to return to this clinic within that time interval for the test to be read.
3. You may experience some irritation or swelling following the test, do not attempt to scratch or apply ice pack as this may affect the outcome of the test. If the swelling or discomfort is excessive please contact us at (703) 222-3555.

I have read and answered the questions above. I hereby consent to have a PPD test - which screens for Tuberculosis, be done on me and I shall return within 48-72 hours to have the test read.

_____
Signature of Patient/Guardian

Section Below is for Office use only

Site of PPD Test: _____Dose Given_____

Date of PPD Test_____Time of PPD Placement_____

Lot # of PPD: _____ Expiration Date_____

Done By:_____

Result: Negative Positive_____(mm)

Read By:_____

Date Test was read:_____ Time Test was read_____