

Testing and Vaccination for Tuberculosis - Scar Present

Name: _____

Date of Birth: _____

1. Have you ever suffered from tuberculosis? Yes No
2. Have you ever had a BCG vaccination? Yes No
Approximate date vaccination was given: _____
3. Have you ever had a skin test for tuberculosis? Yes No
4. If yes, what happened? Reaction No Reaction
5. Do you have a visible scar? Yes No
6. Do you currently have any of the following symptoms?
 - Cough lasting more than 3 weeks Yes No Coughing Blood Yes No
 - Fever Yes No Night sweats Yes No
 - Weight Loss Yes No Loss of Energy Yes No
7. Have you in the last 6 months spent time in areas which have a high risk of TB? Yes No

THE SECTION BELOW IS TO BE COMPLETED BY YOUR DOCTOR AN OCCUPATIONAL HEALTH NURSE, GP OR PRACTICE NURSE

Details of Photographic Evidence: _____

1. Is there a satisfactory scar? Yes No
2. Location of Scar? _____
If there is a scar, no heaf test is required.
3. Date of Heaf/Mantoux (if applicable): _____
4. Graded results of Heaf/Mantoux: _____
5. Date of Chest X-ray: _____

Signature: _____ Date: _____

Print Name: _____ Print Title: _____

NMC/GMC Number: _____

Hospital/Clinic/Surgery: _____ Telephone Number: _____

DEPARTMENT OR SURGERY OFFICIAL STAMP: