

Patient Information Sheet

Mantoux Test & Result Form



Patient Name _____ Laboratory Number _____ Date _____

Clinical History

The following information must be asked of the patient before tuberculin given.
Do you have any of the following?

- | | | | | | |
|------------------------------|------------------------------|-----------------------------|--------------------------------|------------------------------|-----------------------------|
| Cough | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Immune Suppressive illness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Haemoptysis (coughing blood) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any Chronic illness/disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fever/Chills/Temperature | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Are you taking any medications | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Night Sweats | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Chest illnesses | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fatigue/Weakness | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Family History of TB | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Anorexia | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Previous TB contact | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Unexplained Weight Loss | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Worked in high TB risk area | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Previous TB treatment | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Lived in high TB risk area | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Have you had MMR immunisation in the last month? Yes No { **NB:** If yes then tuberculin cannot be given.
Have you had the Measels in the last month? Yes No (Contact Referring Doctor)

If you answered yes to any questions above, please give details:

TB Vaccination

Have you had a BCG vaccination(s)? Yes No Don't Know
If yes, where _____ Year(s) _____

Previous Tuberculin Skin Test (TST)

Have you had a TST/Mantoux? Yes No Don't Know
If yes, where _____ Year(s) _____ Result _____ mm

Office Use Only

Human PPD Dose _____ Time Given _____ am/pm
Avian PPD Dose _____ Time Given _____ am/pm

Batch No. _____ Expiry Given _____
Given By _____

Injection given in: **Left arm** **Right arm** (please circle)

Reading

Mantoux Reading performed By _____ Date _____

Measurement _____

Result

Interpretation	
< 5mm	Negative
6-10mm	Weak Positive
11-14mm	Intermediate Positive
> 15mm	Strongly Positive

Result Entered By _____

Authorised By _____ Date _____



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pathology matters. . .