

# Patient Consent for Examination and Treatment

*You can type your information directly into this form. You will not be able to save; print before closing.*

I have been informed of the risks and benefits of receiving or refusing the procedure/treatment listed below. I have had the opportunity to ask questions, which were answered to my satisfaction. I request and consent that the procedure/treatment below be administered to me.

If you receive a TB Skin Test, you will be given a designated time to return to the health department within 48 to 72 hours. If the TB Skin Test is not read during that time, you will need to have another TB Skin Test applied.

\_\_\_\_\_  
Client's Name (printed)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Nurse's Signature

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## Staff Use Only

PPD given at \_\_\_\_\_ by \_\_\_\_\_ Date \_\_\_\_\_ Date read \_\_\_\_\_ Result \_\_\_\_\_ mm

Date Given	Time Given	Site	Manufacturer	Lot #	Nurse Signature	Date Read	Time Read	Nurse Signature	Induration mm

Disposition:  Discharge  Chest X-ray Date/Time \_\_\_\_\_ Consultation Date/Time \_\_\_\_\_

Referrals/Comments \_\_\_\_\_

## HEALTH PROFESSIONALS

This form was created by the American Lung Association in Indiana with the assistance of our Tuberculosis Quality Task Force. For more information, visit us at **LungIN.org** (click on Programs and Materials, select Tuberculosis). We offer one of the best TB education programs in the country. Our TB program is approved by the American Lung Association, the Indiana State Department of Health and the Centers for Disease Control.

If you have medical-related TB questions, consult with your organization's policies or contact the Indiana State Department of Health TB Department at **317-233-7434**.