

Garrisonville Urgent Care

19 Center Street, Suite 101, Stafford, VA 22556

Tel: (540) 288-2222

PPD CONSENT FORM

Patient Name _____ Today's Date _____

Sex _____ Date of Birth _____ Age _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Telephone (H): _____ (W) _____

Allergies _____ Prior BCG Vaccine _____ Last Menstrual Period _____

I have read and answered the questions above. I hereby consent to have a PPD test - which screens for tuberculosis, be done on me.

Signature of Patient/Guardian

Site of PPD Test: _____

Time of Administration of PPD: _____

Done By: _____

Result: _____

Read By: _____

Date and Time Test was read: _____

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 on _____ 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 (540) 288-2222.