MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

EMPLOYEE HEALTH SERVICES
57 Bee Street – MSC 213
Charleston, SC 29425-2130
Telephone (843) 792-2991
Fax (843) 792-1200

TUBERCULOSIS SKIN TEST (TST) SCREENING

REASON:
- ☐ Pre-Placement ☐ 1st Step ☐ 2nd Step
- ☐ Annual
- ☐ Annual Past Positive Screening
- ☐ Exposure Baseline (with ACORD)
- ☐ Post Exposure (10 week with ACORD)

EMPLOYER:
- ☐ MUHA (Hospital) ☐ Crothall
- ☐ MUSC (University) ☐ Sodexho
- ☐ UMA/CFC ☐ Other_____
- ☐ Volunteer

Last Name_____ First_____ MI____ Birth date____/____/____ Emp ID_____

Dept_____ Position_____ Work #_____ Home #_____

Address_____ City_____ State_____ Zip Code_____

Have you ever had a positive TST? ☐ YES ☐ NO If yes, when?_____

Have you received a live vaccine within the past 30 days? ☐ YES ☐ NO
If yes, what vaccine? ☐ Measles, Mumps, Rubella (MMR) ☐ Varicella (Chickenpox) ☐ Other_____

Are you immune compromised or are you taking any immunosuppressant medications? ☐ YES ☐ NO

Do you <u>currently</u> have any of the following <u>chronic</u> conditions?

YES / NO		YES / NO		YES / NO	
☐	☐ Chronic cough (>3 weeks)	☐	☐ Cough up sputum or blood	☐	☐ Poor appetite
☐	☐ Chronic fatigue (>3 weeks)	☐	☐ Shortness of breath	☐	☐ Recurrent infections
☐	☐ Chronic chest discomfort	☐	☐ Unexpected weight loss		
☐	☐ Persistent low grade fever	☐	☐ Night Sweats (excluding menopause)		

Annual TST is performed to meet DHEC, OSHA, and JCAHO requirements.
- It is **<u>YOUR</u>** responsibility to have your TST read by a licensed person (MD, RN, LPN, RT) within 48-72 hours and return proof to EHS. You may not read your own TST.
- Your TST may show **erythema** (flat redness) or **induration** (hardened, raised area). If your skin test shows **induration**, **it must be read by Employee Health Services**.

I have read and understand the above instructions. I also understand that I will be given one copy of this form free of charge; hereafter there will be a charge for copies. ***I understand that I am advised to keep a copy of this form to avoid future charges.***

Signature_____ **Date**_____

<u>LICENSED PERSONNEL PLEASE COMPLETE THIS SECTION</u>

PLACED: Date_____ **Time**_____AM / PM **LA / RA** **MFT/Lot #**_____ **Exp Date**_____

By (Print Name)_____ (Title)_____ (Signature)_____

(DO NOT cover injection site with band-aid or adhesive tape as some employees may have a reaction to the adhesive.)

READ: Date_____ **Time**_____AM / PM **Results:** Induration _____mm Erythema _____mm

By (Print Name)_____ (Title)_____ (Signature)_____

Return to EHS for 2nd Step TST: ☐ Within 7-30 days ☐ After 30 days ☐ Not applicable

☐ Copy given to Employee, Date_____