GWINNETT ROCKDALE NEWTON
COUNTY HEALTH DEPARTMENTS

QFT and TST Consent Form

Please read the following statements. If you do not understand the questions below, please discuss them with the TB provider BEFORE you have the test performed.

Reason for Screening:

☐ Medical condition/Referred by Doctor

☐ School/Work Requirement

☐ Immigration Clearance

☐ Other Please specify _____

1. I understand that the TB test is only telling me if I came into contact with and am infected by the bacteria that causes tuberculosis. Please initial _____
2. Country of Birth _____
3. History of BCG Vaccine? ☐ Yes ☐ No
4. History of Positive PPD? ☐ Yes ☐ No If yes, state results in (mm) _____
5. Have you received any live vaccinations in the last 30 days? ☐ Yes ☐ No
   Please ask the nurse if you are unsure about what vaccinations you have received.
   If yes, please check all that apply:

   ☐ COVID-19 vaccine ☐ Yellow Fever ☐ MMR ☐ Varicella/chickenpox

   ☐ Zoster/shingles ☐ Smallpox ☐ Intranasal flu vaccine
6. Do you have any medical complications such as HIV, lupus, psoriasis, rheumatoid arthritis, diabetes, pregnancy, etc.? ☐ Yes ☐ No If yes, please list all medical complications. _____
   _____
7. Please list all current medications. _____
   _____
8. Have ever been a resident of a Correctional Facility? ☐ Yes ☐ No
   If yes, please state location of the correction facility. _____
9. Are you ☐ Employed or ☐ Unemployed? If employed, please provide the name and location of your employer. _____

X_____ _____

Patient Signature **Date**

PATIENT LABEL

Nurses Signature _____

PREVENTIVE HEALTH CLINIC
455 Grayson Hwy, Suite 400, Lawrenceville GA 30046 | 678-442-6880 | Fax 770-237-5317 | www.gnrhealth.com