TOURO UNIVERSITY
CALIFORNIA

Form D: PPD

Please answer the questions and follow directions. Ask the PPD administrator to fill in all areas of the form including the clinic address, stamp and providers signature. Attach form C if this is your 1st PPD at

Name ______________________________________ Program & Grad Yr. ____________ DOB: _____________
Please Print

Phone #:______________________________ Email Address: _____________________________________

PPD/TST (Tuberculin Skin Test)

A 2 step PPD is two PPD's completed within 21 days. PPD #1 is placed in the forearm then read within 48 to 72 hours. PPD# 2 is placed 7-18 days later in the opposite forearm then read within 48 to 72 hours. Both PPD's must be documented in mm of induration. <u>Complete PPD's according to your program specific requirements.</u>

Please check: ☐ **2- step PPD** ☐ **1- step PPD**

Yes ☐ No ☐ 1. Have you completed an initial TB Screen and History form? If not, please include it with this PPD.

Yes ☐ No ☐ **2.** Have you traveled outside the US in the past 6 months for a month or longer?
If yes, where & when ____.

Yes ☐ No ☐ **3.** Have you lived with anyone who had active TB in the past year?

Yes ☐ No ☐ **4.** Have you worked or volunteered in a hospital, clinic, shelter or residential setting during the past year? If yes, what setting? ____________________________________.

Yes ☐ No ☐ 5. Have you received **any live vaccines within the last 6 weeks** such as MMR, Varicella, Oral Typhoid or Yellow Fever? A PPD can be given the same day or 6 weeks after receiving a live vaccine.

PPD # 1

Manufacturer:	**Lot:**	**Exp. Date**
Clinic stamp	**Date Placed** ________ **Date Read** ____________ **Time Placed** ________ **Time Read** ____________ **RFA** **LFA** ____________ **mm induration** **Placed by** **Read by:**	Clinic stamp

PPD # 2

Manufacturer:	**Lot:**	**Exp. Date**
Clinic stamp	**Date Placed** ________ **Date Read** ____________ **Time Placed** ________ **Time Read** ____________ **RFA** **LFA** ____________ **mm induration** **Placed by** **Read by:**	Clinic stamp

Comments:

Providers Signature: ____ Date: ____________________

Provider Address/Clinic Stamp: