

**HORIZONS ARTICLE 16 CLINIC
600 SOUTH WILBUR AVENUE
SYRACUSE, NEW YORK 13204
(315) 476-7441**

IDE: _____

FDE: _____

REFERRAL FOR PPD (MANTOUX) TESTING

Please complete all bolded headings as well as questions 1-10 on pg. 2. Horizons will contact you to schedule an appointment once our Medical Director has approved the service. ***Referrals should be submitted at least three weeks prior to due date to allow time for processing.***

Consumer Name: _____ **DOB:** _____

Address: _____ **Zip:** _____

Phone: _____ **Social Security No:** _____

Diagnosis (ICD-9): _____ **Day Program:** _____

Address of Program: _____

Person Completing Referral: _____ **Phone:** _____

Contact to sched. Appt.: _____ **Phone:** _____

Do you request verification: yes no **Medicaid No.:** _____

MSC: _____ **Agency:** _____

Please note: If you do not have Medicaid, you may private pay or choose to go to your own Primary Care Physician. Please contact the clinic for details regarding private pay.

I voluntarily give permission for the Horizons Clinic nurse to administer the required PPD (Mantoux) testing in accordance with the Medical Director's authorization. I understand that Horizons Clinic is required by law to inform the Health Department if I have a positive reading. A copy of the PPD (Mantoux) verification will be forwarded and should be given to the primary care physician for their records.

Referral must be signed by the consumer (unless he/she has a Legal Guardian in which case the Legal Guardian must sign). Unsigned referrals will not be processed.

Signature of consumer/legal guardian: _____ **Date:** _____

Clinic Treatment Coordinator: _____ **Date:** _____

Any RN employed by The Arc of Onondaga may administer a Mantoux skin test utilizing Purified Protein Derivative (PPD) 0.1ml intradermally.

Approval of Medical Director: _____ **Date:** _____

License # 132890

Additional PPD (Mantoux) verification should be sent to: (please include name, address, and zip.)

HORIZONS ARTICLE 16 CLINIC
TUBERCULOSIS SCREENING QUESTIONNAIRE
(This is not a questionnaire for those with a history of Positive PPD)

Important

The only contraindication to PPD (Mantoux) skin testing is a history of Tuberculosis disease or a positive skin test result. If a prior positive skin test or TB disease is indicated in your medical history, you should not have this test repeated.

Any test not read within 48-72 hrs after administration will be invalid and must be repeated.

Consumer Name: _____
(please print)

Questions 1-10 MUST be completed or the referral will not be processed:

1. Have you ever had skin testing for tuberculosis? Yes: No:
2. If yes, date of the most recent completed testing: _____
Results: Positive: Negative:
If the result was positive, was a chest x-ray completed? Yes: No:
3. Do you have any allergies? Yes: No:
If yes, please list here: _____
4. Have you had a recent live virus vaccination (measles, mumps, rubella, chicken pox, or gamma globulin)? Yes: No:
5. Do you or have you recently taken immunosuppressant drugs (i.e. Prednisone, Cortisone, or any other types of corticosteroid)? Yes: No:
6. Are you on any type of chemotherapy? Yes: No:
7. Are you pregnant? Yes: No:
8. Are you diabetic? Yes: No:
9. Signature of person completing form: _____
10. Date: _____

Consumer Name: _____ DOB: _____

FOR OFFICE USE ONLY

Step #1: On File See Attached Requires two-step procedure

Mantoux PPD 0.1 ml Administration Intradermally

Test administered at Horizons Clinic, 600 South Wilbur Ave. Syracuse, NY 13204

Date: _____ Manufacturer: _____

Lot No.: _____ Expiration Date: _____

Location: (R) Forearm / (L) Forearm Time Given: _____ End Time: _____

Signature of Nurse Administering: _____

Mantoux PPD Reading (48-72 hours after administration)

Date: _____ Measurement of induration: _____ Results: _____

Follow up action taken for positive results: _____

Signature of Nurse Reading: _____

Step #2: Mantoux PPD 0.1 ml Administration Intradermally

Test administered at Horizons Clinic, 600 South Wilbur Ave. Syracuse, NY 13204

Date: _____ Manufacturer: _____

Lot No.: _____ Expiration Date: _____

Location: (R) Forearm / (L) Forearm Time Given: _____ End Time: _____

Signature of Nurse Administering: _____

Mantoux PPD Reading (48-72 hours after administration)

Date: _____ Measurement of induration: _____ Results: _____

Signature of Nurse Reading: _____