*[Replace this text with your organization’s identifier.]*

ADULT/STAFF CONSENT FORM

Interferon Gamma Release Assays (IGRA)

The TB blood test (IGRA) is a test that shows whether a person has been infected with tuberculosis bacteria. The test requires a blood draw and results can be available within 10 days. If the test is positive, additional tests are needed to determine if you have latent TB infection or TB disease.

|  |
| --- |
| **You cannot be tested without your consent and signature. Please fill out the portion below, sign, and return with the Health Questionnaire on the date of your appointment.** |

**PLEASE CHECK ONE OF THE BOXES BELOW** for the (IGRA) TB blood test and Chest X-Ray:

❑ I consent to TB testing by the ***[Replace this text with your organization name]***, Tuberculosis Control Program by means of an IGRA blood test. I understand that this blood test may need to be repeated (8-10 weeks after last contact), and I give consent for a second test if needed.

I consent to receive a chest x-ray to rule out tuberculosis disease if needed.

### OR

❑ I have had a documented positive tuberculin skin test reaction/positive TB blood test in the past.

Date of the TB skin test \_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_ Result: \_\_\_\_ mm

Date of positive TB Blood test (IGRA) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Doctor/medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to receive a chest x-ray to rule out active tuberculosis disease.

### OR

❑ I will be TB tested by my own health provider to rule out TB infection/disease and will provide ***[Replace this text with your organization name]*** with documentation of the results by ***[Replace with appropriate date]*.**

Doctor/medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please provide the following information whether you have consented to services or not.**

Name (Print): Date of Birth: \_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_

Home Address:

Telephone (day): Telephone (evening/cell/message):

CONSENT/AUTHORIZATION – This consent is valid through ***[Replace with appropriate date]***

**Signature**  Date:

**COMPLETE AND BRING THIS FORM AND HEALTH QUESTIONNAIRE WITH YOU ON THE DATE OF YOUR APPOINTMENT**

**You cannot be tested without this consent.**

**Please return this form even if you do not consent to testing.**

For questions about this form, you may call ***[Replace this text with your organization name and contact information]***