HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT OF RECEIPT

I have received a copy of the Oxford Immunotec, Inc. Notice of Privacy Practices.

__________________________________________
(Signature of patient) (Date)

__________________________________________
(Print Name)

For Oxford Immunotec, Inc. use only

A written signature of this form was attempted but could not be obtained because:

_____ The individual refused to sign

_____ An emergency or other situation prevented obtaining this acknowledgment

Other: ____________________________________________________________________________
CONSENT FOR TB TEST

This consent form documents my consent to the T-SPOT®. TB test for active and latent (or inactive) tuberculosis (TB) infection. I understand that this test is being requested as part of a TB screening event conducted on behalf of CUSTOMER NAME (“Institution”).

RISK SUMMARY

The T-SPOT. TB test is a blood test requiring a sample of approximately 6mL of blood drawn by needle from my arm. I understand that there is a slight risk of bruising and mild discomfort associated with a blood draw. Another risk of a blood draw is the infrequent occurrence of fainting. The testing presents a risk to my privacy because the results will be shared with Institution.

I understand that I may withdraw my consent at any time; however, I may be requested to undergo alternative TB testing.

My signature below indicates that I have read and understand this consent form, have had an opportunity to ask questions and that all of my questions have been answered.

CONSENT

Signature: ________________________________

Print Name: ______________________________

Date: _________________

T-SPOT is a registered trademark of Oxford Immunotec Ltd.
Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please circle the country, below)

Afghanistan

Algeria

Angola

Anguilla

Argentina

Armenia

Azerbaijan

Bangladesh

Belarus

Belize

Benin

Bhutan

Bolivia (Plurinational State of)

Bosnia and Herzegovina

Botswana

Brazil

Brunei Darussalam

Bulgaria

Burkina Faso

Burundi

Cabo Verde

Cambodia

Cameroon

Central African Republic

Chad

China

China, Hong Kong SAR

China, Macao SAR

Colombia

Comoros

Congo

Côte d'Ivoire

Democratic People's Republic of Korea

Democratic Republic of the Congo

Eritrea

Dominican Republic

Ecuador

El Salvador

Equatorial Guinea

Ethiopia

Fiji

Gabon

Gambia

Georgia

Ghana

Greenland

Guam

Guatemala

Guinea

Guinea-Bissau

Guyana

Haiti

Honduras

India

Indonesia

Iraq

Kazakhstan

Kenya

Kiribati

Kuwait

Kyrgyzstan

Lao People's Democratic Republic

Latvia

Lesotho

Liberia

Libya

Lithuania

Madagascar

Malawi

Malaysia

Maldives

Mali

Marshall Islands

Mauritania

Mauritius

Mexico

Micronesia (Federated States of)

Montenegro

Morocco

Mozambique

Myanmar

Namibia

Nauru

Nepal

New Caledonia

Nicaragua

Niger

Nigeria

Northern Mariana Islands

Pakistan

Palau

Panama

Papua New Guinea

Paraguay

Peru

Philippines

Portugal

Qatar

Republic of Korea

Republic of Moldova

Romania

Russian Federation

Rwanda

Sao Tome and Principe

Senegal

Serbia

Sierra Leone

Singapore

Solomon Islands


Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, check the countries or territories, above)

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?
Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?  

☐ Yes  ☐ No

Have you ever had a positive TB skin test or IGRA blood test?  

Yes _____ No ____

Have you ever received the BCG (bacille Calmette-Guerin) vaccination?  

Yes _____ No ____

Have you had an MMR or Chicken Pox vaccine in the past 6 weeks?  

Yes _____ No ____

**Do you have any allergies to latex or rubber products?**  

Yes _____ No ____

**TB Symptom Check**

**In the last year have you had any of the following:**

☐ Cough (especially if lasting for 3 weeks or longer) with or without sputum production  
☐ Coughing up blood (hemoptyis)  
☐ Chest pain  
☐ Loss of appetite  
☐ Unexplained weight loss  
☐ Night sweats  
☐ Fever

Please read carefully

The T-Spot TB test is a blood test for tuberculosis (TB) screening, an alternative to the TB skin test. This TB test is performed using blood collection and is not affected by previous BCG vaccination. Also, there are no adverse effects for women who are pregnant since it is a blood draw and not an injection. Your TB test results will be available within 4 business days after the blood draw. The TB hold will be removed from your student account after reviewing the lab results and determining you do not have active TB. The TB blood test is not always conclusive and may require a follow-up chest x-ray at your own expense. The Student Health Center will contact you if a chest x-ray is required.

The cost of the T-Spot TB test administered by the Student Health Center is $75.

Consent for TB Screening

By signing below, you are giving your consent for the Student Health Center to administer the T-Spot TB test, acknowledging that you have read and understand the information provided above, and that you agree to pay the $75 charge at the time of service.

I have read and understand the above information and consent to the test.

Signature: ______________________________________________ Date: __________________________

For Student Health Center Only

T-spot TB Blood Test- Standing Order: S. Naheed, MD

Date Collected: _____________________________  Time Collected: ___________________________

Phlebotomist/Nurse Signature: ________________________________________________________

Revised 06/28/2017