

Instructions for Medical Examination for Immigration

Please call between 9 a.m. and 4 p.m. to schedule an appointment.

For Inova Urgent Care in Centreville, call **703-830-5600**.

For Inova Urgent Care in Vienna, call **703-938-5300**.

Please fill out all the forms you have downloaded from this web site.
Bring these forms, along with the following, to your appointment:

- Any immunization / vaccine records you may have
- Passport-size photo to attach to your I-693 form
- Photo ID, i.e., driver's license or passport
- Form of payment for the exam (cash, credit card or personal check)



PLEASE COMPLETE THE FOLLOWING INFORMATION
(PLEASE PRINT CLEARLY AND LEGIBLY)

REASON FOR VISIT: _____

PATIENT INFORMATION:

PATIENT LAST NAME: _____ FIRST: _____ MI: _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE CONTACT: HOME: (____) _____ CELL: (____) _____

SOCIAL SECURITY #: ____ - ____ - ____ SEX: M F DATE OF BIRTH: ____ / ____ / ____ AGE: ____

EMERGENCY CONTACT: _____

LOCAL ADDRESS (IF DIFFERENT): _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE CONTACT: HOME: (____) _____ CELL: (____) _____

IF PATIENT IS A MINOR:

PARENT / GUARDIAN NAME: _____ RELATIONSHIP: _____

ADDRESS (IF DIFFERENT): _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE CONTACT: HOME: (____) _____ CELL: (____) _____

IF YOU ARE COVERED BY AN INSURANCE PLAN, PLEASE PRESENT YOUR CARD TO THE
RECEPTIONIST.

(S)HE WILL ADVISE YOU IF WE ACCEPT YOUR INSURANCE AND MAKE A COPY OF YOUR CARD FOR
OUR RECORDS.

NAME OF INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP TO PATIENT: _____

ID#/POLICY NUMBER: _____ GROUP # _____

DATE: _____

TUBERCULIN SKIN TEST (TST) REPORT

UCCP 540-338-4995 FAX 540-338-2483
 HEALTHPLEX OHC 703-797-6844 FAX 703-797-6859
 ALEXANDRIA OHC 703-504-6600 FAX 703-504-6607
 ECCF 703-877-8200 FAX 703-934-5076
 UCCD 703-722-2500 FAX 703-327-1850
 UCCC 703-830-5600 FAX 703-830-6942
 UCCV 703-938-5300 FAX 703-242-0726

Name: _____ Date: ____/____/____

S.S.N.: _____ - _____ - _____ Date of Birth ____/____/____ Sex: Male Female

Phone: () _____ - _____ Employer: _____

Reason for Testing: ____Preplacement ____Annual ____Post Exposure ____Immigration

QUESTIONS

1. Have you ever had a **TB** skin test before? ____Yes ____No ____I do not know
 If yes, was it ever positive ____yes ____No ____I do not know
 If it was positive, how long ago and where did you receive this test: _____
 Did you receive any treatment or medication for TB? _____

Do you have any of the following:

- a. Sensitivity / allergy to PPD serum? ____Yes ____No
- b. Received polio vaccine in the last 4-6 weeks? ____Yes ____No
- c. Received MMR in the last 4-6 weeks? ____Yes ____No
- d. Received varicella vaccine in the last 4-6 weeks? ____Yes ____No
- e. Receiving corticosteroid/other immunosuppressive therapy? ____Yes ____No

3. Have you ever received **BCG** vaccine? ____Yes ____No
 If yes, how long ago and where did you receive this inoculation: _____

*******You must return within 48-72 hours to have the test results read. *******

Return On: ____/____/____ After: ____:____ OR ____/____/____ Before: ____:____

I have read and understand that these are the only times in which this TB test will be accurately read.

Signature: _____ Date: ____/____/____

*****The patient named above has been tested for exposure to Tuberculosis using Purified Protein Derivative diluted to equal standard 5 Tuberculin Units, in the amount of 0.1cc intradermally. This is the standard Mantoux test.

Date of Placement: ____/____/____ Time of Placement: ____:____

Location of Placement: Right Forearm Left forearm Other Site _____

Lot #: _____ Exp. Date: ____/____/____ Manufacturer: _____

Placed By: _____ R.N.

Date of Reading: ____/____/____ Time of Reading: ____:____

RESULTS: Negative ____MM Positive ____MM

- This person has completed negative (0mm) testing.
- Incomplete testing, failed to return at specified time.
- Requires 2-step testing Yes No Return for #2 on ____/____/____
- Chest X-ray done Yes No Result: _____
- Referred to PMD or County Health Department for possible medication and/or treatment

Reading Completed by: _____ R.N. / M.D.