**GP REQUEST FORM FOR MANTOUX / BCG VACCINATION**

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| Address:  Contact Tel No: | GP Name:  Surgery Address:  Tel No: |
| **REASON FOR MANTOUX / BCG REQUEST** (Please tick appropriate box)  New Entrant □ ‘At risk’ Child under 16 years\*\* □  Individual at occupational risk under 35 years \* □ ‘At risk’ Traveller under 16 years\* \*\* □  \*Individual at occupational risk- occupational groups more likely than general public to come into contact with TB: includes healthcare workers; laboratory workers; veterinary workers; prison workers; care home workers; hostel staff  \*\*At risk child – previously unvaccinated children under 16 years of age with a parent/grandparent born in a country with an incidence of TB greater than 40/100,000 or who were born or have lived for more than 3 months in a country with an incidence of TB greater than 40 cases per 100,000 or who have been identified as part of TB contact screening as needing a BCG vaccination  \*\*\* At risk traveller -vaccine recommended for those under 16 years going to live or work in a country with a TB incidence of more than 40 cases per 100,000  Please refer to guidelines for detailed inclusion / exclusion criteria www.immunisation .nhs.uk  Please note there is no data on protection afforded by BCG vaccine when given to adults over 35 years | |
| **CHECKLIST FOR CONTRAINDICATIONS TO MANTOUX TEST AND / OR BCG**  History of having had Tuberculosis YES □ NO □  Previous BCG (record or evidence of scar) YES □ NO □  Previous adverse reaction to a tuberculin skin test YES □ NO □  Immune Suppression – disease or medication YES □ NO □  Confirmed or possible HIV infection YES □ NO □  Pregnancy YES □ NO □ | |
| **Patient Specific Directions for Administration of Tuberculin PPD (SSI) for Mantoux Testing**  **Patient Specific Directions for Administration of AJ Vaccines BCG Vaccination**  (Mantoux test and BCG vaccination To be requested and signed by patient’s doctor)  The above named patient is eligible for Mantoux testing – no contraindications have been identified.  The above named patient is eligible for BCG vaccination- no contra indications have been identified.    Doctor’s Name (Print)…………………………………………………Signature……………………………………………. Date………………………….. | |