



uOttawa

Student Placement Risk Management

One-Step Tuberculin Skin Test (TST)

Program				
Medicine <input type="checkbox"/> <input type="checkbox"/> Undergraduate <input type="checkbox"/> Postgraduate <input type="checkbox"/> Postgraduate Elective	Nursing <input type="checkbox"/> <input type="checkbox"/> Generic program (select campus): <input type="checkbox"/> Ottawa <input type="checkbox"/> Woodroffe <input type="checkbox"/> Pembroke <input type="checkbox"/> Bridging <input type="checkbox"/> 2nd Entry <input type="checkbox"/> Graduate MScN <input type="checkbox"/> Diploma in PHCNP	Rehabilitation <input type="checkbox"/> <input type="checkbox"/> Audiology <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Speech-Language Pathology	Education <input type="checkbox"/> <input type="checkbox"/> Undergraduate <input type="checkbox"/> Master of Education in Counselling Psychology	Social Sciences <input type="checkbox"/> <input type="checkbox"/> Clinical Psychology <input type="checkbox"/> Social Work
		Nutrition <input type="checkbox"/>	Sciences <input type="checkbox"/> <input type="checkbox"/> Ophthalmic Medical Technology	Human Kinetics <input type="checkbox"/>
Last name: _____ First name: _____ Student number: _____ Year of admission: _____ Email: _____ Telephone: _____ Date of birth (yy/mm/dd): _____ / _____ / _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary				
Tuberculin Skin Test				
Step 1: Date implanted (yy/mm/dd): _____ / _____ / _____		Time: _____ : _____ AM <input type="checkbox"/> PM <input type="checkbox"/>		
Results must be read within 48-72 hours of implantation. Date read (yy/mm/dd): _____ / _____ / _____		Time: _____ : _____ AM <input type="checkbox"/> PM <input type="checkbox"/> Result: _____ mm of induration		
If induration is ≥10mm, a chest X-ray is required:				
Date of CXR (yy/mm/dd): _____ / _____ / _____		Results: _____ (Attach Report)		
Attesting Signature of Health Care Professional (HCP)				
Name: _____ Signature: _____ Title: _____ Date (yy/mm/dd): _____ / _____ / _____		Stamp:		

Please email this form to your corresponding Clinical Placement Risk Management Advisor at the University of Ottawa.