

Center Number: _____ Participant Number: _____ Participant's Initials: _____
first middle last

Delayed-type Hypersensitivity (DTH) Test Worksheet

Date: ____/____/____ OR Not done → Specify reason (use codelist below): _____
day month year

Vital signs: Pulse rate: _____ bpm Blood pressure: ____/____ Temperature: ____ . ____ °C
systolic diastolic

(Do not administer test if vital signs are not normal for the individual. Temperature higher than 38°C is considered fever. Pulse rate is too high if greater than 90. If vital signs are not within normal range, it would be up to the physician to determine if they can proceed with the test.)

Medications: _____ Supplements: _____

Allergies (if allergic to eggs, mercury, thimerosal, or latex, do not administer DTH): _____

DTH Test Questions

Note: If Yes to questions 2, 3, 4, 5, 6, 7, or 8, participant not eligible for skin testing If Yes to questions 9 or 10, do not administer tetanus or the specific antigen.

1 Have you ever had a skin test in the past? _____ ☐ No ☐ Yes →

If Yes: A Reason for test: _____ Date of test: ____/____/____
day month year

B List any positive results: _____

C Body site test administered: _____

D Any allergic reactions? ☐ No ☐ Yes → If Yes, do not administer test.

2 Have you had a febrile illness and/or infection within the past 2 weeks? _____ ☐ No ☐ Yes →

If Yes: Specify: _____

3 Have you taken any oral or parenteral steroids 10 mg/day within the past month? _____ ☐ No ☐ Yes →

If Yes: List (topical and inhaled are OK): _____

4 Have you taken any antibiotics in the past three weeks? _____ ☐ No ☐ Yes

5 Any ASA/NSAIDs/antihistamines in the last 72 hours? _____ ☐ No ☐ Yes

6 Any history of DM, CAD, heart disease, AIDS, cancer, substantial recent unexplained weight loss? ☐ No ☐ Yes

7 Any history of anaphylaxis with unknown cause, severe allergies or asthma? _____ ☐ No ☐ Yes

8 Any immunization within the last 6 weeks or flu shot within the last 3 weeks? _____ ☐ No ☐ Yes

Note: Tetanus test will not be administered if vaccinated within 6 weeks from DTH test date.

Not Done Codelist: 1 Participant refused 2 Clinician unable to obtain 3 Insufficient time 4 Instrument failure 5 Not required

Do not submit to DCRI. Retain at site at secure location.

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9 Adverse reaction to tetanus vaccine? ☐₀ No ☐₁ Yes

10 Specific antigen allergy? ☐₀ No ☐₁ Yes →
If Yes: Specify: _____ → **Do not plant.**

Comments: _____

Signature

RN signature: _____

Date: ____/____/____
day month year

Do not submit to DCRI. Retain at site at secure location.