TEXAS Department of State Health Services

Drugs and Medical Devices Group
Policy, Standards and Quality Assurance Unit

REPORT OF INFECTION OR ALLERGIC REACTION BY A TATTOO OR BODY PIERCING STUDIO

A COPY OF THIS REPORT SHALL BE PROVIDED TO THE TEXAS DEPARTMENT OF STATE HEALTH SERVICES WITHIN FIVE WORKING DAYS OF THE OCCURRENCE OF (OR KNOWLEDGE OF) ANY INFECTION OR ALLERGIC REACTION RESULTING FROM A BODY PIERCING OR THE APPLICATION OF A TATTOO.

Mail or fax the completed report to: Texas Department of State Health Services, Division for Regulatory Services, Drugs & Medical Devices Group MC 1987, P.O. Box 149347 Austin, Texas 78714-9347, or fax (512) 834-6759, Attention: Tattoo & Body Piercing Program.

SECTION 1 – TATTOO OR BODY PIERCING STUDIO INFORMATION

1. Date/Time Incident Reported by Client	2. Name of Person Completing Report
3. Name and Address of Studio (where procedure was performed)	4. Name of Artist
	5. Business Telephone No.

SECTION 2 – PROCEDURE INFORMATION

6. What type of procedure was performed?
☐Tattoo ☐Permanent Cosmetics ☐Body Piercing

7. On what part of the body was the procedure performed?

☐Nose	☐Tongue	☐Navel	☐Back
☐Lip	☐Face	☐Genitals	☐Abdomen
☐Eyebrow	☐Ear	☐Hand	☐Other:
☐Eyelid	☐Nipple	☐Arm	_____

8. Date/Time of Procedure

9. How long did the procedure take?
☐Less than 1 Hour ☐1 to 2 Hours ☐2 to 3 Hours ☐Greater Than 3 Hours

10. Color/pigments used (manufacturer & catalogue #):	11. Type of jewelry used (manufacturer & catalogue #):

SECTION 3 – CLIENT INFORMATION

12. Name of Client (Last, First, MI)	13. Date of Birth	14. Sex ☐Male ☐Female
15. Street Address	16. Home Telephone No.	

17. City, State, Zip Code	18. Business Telephone No.

19. For a tattoo procedure, did the client do any of the following within two weeks after the procedure?

a. Go swimming? ☐Yes ☐No

b. Go to the beach? ☐Yes ☐No

c. Go in the sun? ☐Yes ☐No

For a body piercing procedure, did the client do any of the following within six weeks after the procedure?

d. Participate in an activity that may have introduced contaminants into the pierced area? ☐Yes ☐No

If the response was "Yes" to any of the above questions, please explain:

SECTION 4 – MEDICAL AND TREATMENT INFORMATION

20. Did the client report any of the following symptoms?

☐Inflammation (e.g. redness; swelling)

☐Fever ☐Allergic Reaction ☐Drainage of Pus

☐Pain ☐Rash ☐Blurred Vision

☐Other:_____

21. What date did the first symptoms appear?

22. Was the client admitted to a hospital, emergency clinic or emergency room? ☐Yes ☐No

a. Name of Hospital: _____

b. Location: _____

c. Admission Date: _____

d. Telephone No.:

23. Did the client see a physician or other health care professional for this skin reaction or infection?

☐Yes ☐No

a. Name of physician or health care professional: _____

b. Address: _____

c. Date seen: _____

d. Telephone No.:

24. Did the physician prescribe any medications? ☐Yes ☐No	25. Did the physician or health care professional confirm a diagnosis? ☐Yes ☐No

SECTION 5 – OTHER RELEVANT INFORMATION