



**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 Incident Reported by Client	2. Name of Person Reporting Incident	
3. Time Incident Reported	4. Name of Artist	
5. Name and Address of Studio (where procedure was performed)	6. Business Telephone No.	
SECTION 2 – PROCEDURE INFORMATION		
7. What type of procedure was performed? <input type="checkbox"/> Tattoo <input type="checkbox"/> Permanent Cosmetics <input type="checkbox"/> Body Piercing		
8. On what part of the body was the procedure performed? <input type="checkbox"/> Nose <input type="checkbox"/> Tongue <input type="checkbox"/> Navel <input type="checkbox"/> Back <input type="checkbox"/> Lip <input type="checkbox"/> Face <input type="checkbox"/> Genitals <input type="checkbox"/> Abdomen <input type="checkbox"/> Eyebrow <input type="checkbox"/> Ear <input type="checkbox"/> Hand <input type="checkbox"/> Other: <input type="checkbox"/> Eyelid <input type="checkbox"/> Nipple <input type="checkbox"/> Arm      _____		
9. Date/Time of Procedure		
10. How long did the procedure take? <input type="checkbox"/> Less than 1 Hour <input type="checkbox"/> 1 to 2 Hours <input type="checkbox"/> 2 to 3 Hours <input type="checkbox"/> Greater Than 3 Hours		
11. Color/pigments used (manufacturer & catalogue #):	12. Type of jewelry used (manufacturer & catalogue #):	
SECTION 3 – CLIENT INFORMATION		
13. Name of Client (Last, First, MI)	14. Date of Birth	15. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
16. Street Address	17. Home Telephone No.	
18. City, State, Zip Code	19. Business Telephone No.	

20. 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**

21. Did the client report any of the following symptoms?
- Inflammation (e.g. redness; swelling)
  - Fever                       Allergic Reaction     Infection
  - Pain                             Rash                             Blurred Vision
  - Other: \_\_\_\_\_

22. What date did the first symptoms appear?

23. 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.: \_\_\_\_\_

24. 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.: \_\_\_\_\_

25. Did the physician prescribe any medications?
- Yes     No

\_\_\_\_\_

26. Did the physician or health care professional confirm a diagnosis?
- Yes     No

**SECTION 5 – OTHER RELEVANT INFORMATION**

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