

**Virginia Department of Health**  
**REPORT OF TUBERCULOSIS SCREENING**

DATE \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**To Whom It May Concern:**

**The above named individual has been evaluated by** \_\_\_\_\_  
(Name of health dept./facility)

**Tuberculin Skin Test (TST)**

Date given: \_\_\_\_\_ Date read: \_\_\_\_\_

Results: \_\_\_\_\_mm      \_\_\_ Negative      \_\_\_ Positive

**Interferon Gamma Release Assay**      Alternative test for the tuberculin skin test (TST)

Date drawn \_\_\_\_\_ Time drawn \_\_\_\_\_

Result:    \_\_\_Neg    \_\_\_Pos    \_\_\_Indeterminate    \_\_\_Borderline

**Chest X-Ray Result**

Date of Chest x-ray \_\_\_\_\_ Date of Positive Skin Test/IGRA \_\_\_\_\_

\_\_\_ No evidence of active tuberculosis

\_\_\_ Chest x-ray abnormal, active tuberculosis to be ruled out

**Based on the above report:**

\_\_\_ **The individual listed above has no symptoms compatible with active tuberculosis. The individual is free of Tuberculosis in a communicable form.**

\_\_\_ **Active tuberculosis cannot be ruled out in the individual listed above. The individual has been referred to a physician or health department for further evaluation.**

Signature \_\_\_\_\_  
(MD or Health Department Official)

Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_