REPORT OF TUBERCULOSIS SCREENING

Name: ______________________________________ Date of Birth: _____________

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by ______________________________.
(Name of health dept/facility/practice)

Chest X-ray Report – No active disease Date of Chest X-ray: ___________

The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature/Title: ______________________________________ Date: _______________
(MD/designee or Health Department Official)
Print Name/Title: ___________________________________ Phone: _______________
Address: _______________________________________
____

Chest X-ray Report – Abnormal Report Date of Chest X-ray: ____________

Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.

Signature/Title: ______________________________________ Date: _______________
(MD/designee or Health Department Official)
Print Name/Title: ___________________________________ Phone: _______________
Address: _______________________________________
____

Tuberculin Skin Test (PPD) Date given: _______________ Date read: _____________

Results: ___________ mm _____ Negative _____ Positive

Based on the above information the above named individual can be considered free of tuberculosis in communicable form.

Signature/Title ______________________________________ Date ________________
(MD/designee or Health Department Official)
Print Name/Title: ___________________________________ Phone: _______________
Address _______________________________________
____

032-05-0420-00-eng (02/12)