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 _____
_____