REPORT OF TUBERCULOSIS SCREENING EVALUATION

Name _____ **Birthdate** _____/_____/_____

Address _____

_____

1. **Date and result of most recent Mantoux tuberculin skin test: Date: _____/_____/_____**
   mm of induration _____

2. **Check here if previously positive and above information unknown _____**

3. **Check here if exhibiting TB-like symptoms _____**

4. **If TB skin test is 10 mm or greater (5mm in the HIV infected), previously positive or if TB-like symptoms exist, *respond to the following:***

   a. **Date of last chest x-ray evaluation: Date: _____/_____/_____**

   b. **Is chest x-ray suggestive of active TB? *(circle one)*** **YES** **NO**

   c. **Were sputum smears collected and analyzed for the presence of Acid Fast Bacilli (AFB)? *(circle one)*** **YES** **NO**

   d. **If 4c is YES, were three consecutive smears negative for AFB? *(circle one)*** **YES** **NO**

5. **Based on the above information, is this individual free of communicable TB? *(circle one)*** **YES** **NO**

6. **Name of licensed physician, physician's designee or local health department official completing the evaluation:**

   _____ _____
   Print Name **Phone**

7. **Signature of license physician, physician's designee or local health depa rtment official completing evaluation:**

   _____ _____/_____/_____
   Signature **Date**