

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 (PPD)
Date given _____ Date read _____
Results : _____ mm _____ Negative _____ Positive
Signature _____ Date _____
(MD or Health Department Official)
Address _____ Phone _____

Chest X-ray Report – No active disease
Date of Chest x-ray _____
_____ No evidence of active tuberculosis
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 _____ Date _____
(MD or Health Department Official)
Address _____ Phone _____

Chest X-ray Report – Abnormal Report
Date of Chest x-ray _____
_____ Chest x-ray abnormal, active tuberculosis to be ruled out
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 _____ Date _____
(MD or Health Department Official)
Address _____ Phone _____