

Record of Tuberculosis (TB) Screening

Name: _____ Hire/Admission Date: _____

First (1st) Step not required, because negative PPD result documented within the last thirty (30) days: YES <input type="radio"/> NO <input type="radio"/> <small>If "YES" – must attach documentation to this sheet</small>

Has individual ever had a positive (+) PPD result before? YES <input type="radio"/> NO <input type="radio"/> <small>If "YES" – must attach necessary documentation from Health Department Physician – that proper treatment was completed and/or Negative Chest X-Rays, are documented if available within last twelve (12) months.</small>

First Step - TB Test

Route		Site		Dose	
Brand		Lot #		Exp. Date	
Given By (Print – LN, FN)					Title
Signature				Date/Time	

Results

Date/Time Read		Results (millimeters)	
Read By (Print – LN, FN)			Title
Signature			Follow-Up Required Yes <input type="radio"/> No <input type="radio"/>

Second Step - TB Test

Route		Site		Dose	
Brand		Lot #		Exp. Date	
Given By (Print – LN, FN)					Title
Signature				Date/Time	

Results

Date/Time Read		Results (millimeters)	
Read By (Print – LN, FN)			Title
Signature			Follow-Up Required Yes <input type="radio"/> No <input type="radio"/>

Date/Time	Follow-Up Documentation