

Do not fax, retain in records.

Lab Results

LABS			COMMENTS
CBC	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done Hgb:_____
Basic Metabolic Profile	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done
Urinalysis	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done
HIV	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done
Hepatitis B	Surface Antigen <input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
	Immune <input type="checkbox"/> Yes <input type="checkbox"/> No		
Cholesterol	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done/N/A
UPT	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
Blood Lead Level	WNL?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Not done/N/A _____ug/dl
Hepatitis C	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
RPR	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
Chlamydia/GC	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Not done/N/A
Varicella IgG	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal		<input type="checkbox"/> Not done/N/A
MMR	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/Equivocal		<input type="checkbox"/> Not done/N/A

TB Screening/Testing Results

IGRA <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> TSpot <input type="checkbox"/> QFT Date:_____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/Equivocal
TST <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Applied:_____ Date Read:_____	Result:_____ mm <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Chest x-ray	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Not done/N/A
Treatment	<input type="checkbox"/> Active Disease <input type="checkbox"/> LTBI <input type="checkbox"/> No Treatment	Comments:

Place Patient label here