Name: DOB: | |

TST: mm induration Date Read: | |

IGRA: ❑ Pos ❑ Neg Date: | |

Chest X-Ray: Date: | | ❑ Normal ❑ Abnormal (Stable)

Treatment Completed: ❑ Yes ❑ No (Contact Provider)

Name of Drug(s):

Started: | | Stopped: | | # Mos:

Provider Name:

Signature: Phone: ( )

Name: DOB: | |

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Started: | | Stopped: | | # Mos:

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Signature: Phone: ( )

Your TB Test and Treatment Record

Show this card to your doctor. Report the following symptoms if they last more than 2 weeks:

Cough   Shortness of breath   Chest pain

Coughing up blood   Feeling weak or tired   night sweats

Fever and chills   Losing weight without trying

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