Name:	DOB:	Name:		DOB:
TST: mm induration	Date Read:	TST: mm i	induration Date F	Read:
IGRA: □ Pos □ Neg □ Indet	IGRA: 🗆 Pos 🗆 Neg 🗆 Indeterminate Date:			
Chest X-Ray: Date: 🗆 Normal 🗆 Abnormal (Stable)		Chest X-Ray: Date: 🛛 Normal 🗖 Abnormal (Stable)		
Treatment Completed: 🛛 Yes 🗆 No (Contact Provider)		Treatment Compl	eted: 🗆 Yes 🗆 No	o (Contact Provider)
Name of Drug(s):		Name of Drug(s):		
Started: Stoppe	ed: #Mos:			#Mos:
Provider Name:		Provider Name: _		
Signature:	Phone:	Signature:	P	hone:
Name:	DOB:	Name:		DOB:
	Date Read:			Read:
IGRA: 🗆 Pos 🗆 Neg 🗆 Indeterminate Date:		 IGRA: □ Pos □ Neg □ Indeterminate Date:		
Chest X-Ray: Date: □Normal □ Abnormal (Stable)		Chest X-Ray: Date: □Normal □ Abnormal (Stable)		
Treatment Completed:	Treatment Completed: 🗆 Yes 🗆 No (Contact Provider)			
		Name of Drug(s):		
	ed: #Mos:			#Mos:
Signature:	Phone:	Signature:	P	hone:
Name:	DOB:	Name:		DOB:
TST: mm induration	TST: mm induration Date Read:			
IGRA: Pos Neg Indet	 IGRA: □ Pos □ Neg □ Indeterminate Date:			
Chest X-Ray: Date: E			al 🗖 Abnormal (Stable)	
Treatment Completed: Yes No (Contact Provider)				o (Contact Provider)
Name of Drug(s):		Name of Drug(s):		
	ed: #Mos:			#Mos:
Signature:	Phone:			hone:
Name:	DOB:	Name:		DOB:
	Date Read:			Read:
IGRA: □ Pos □ Neg □ Indeterminate Date:		 IGRA: □ Pos □ Neg □ Indeterminate Date:		
Chest X-Ray: Date: E	Chest X-Ray: Date: □Normal □ Abnormal (Stable)			
Treatment Completed:	Treatment Completed: 🛛 Yes 🗆 No (Contact Provider)			
Started: Stoppe	ed: #Mos:			#Mos:
	Phone:			hone:
Name:	DOB:	Name:		DOB:
TST: mm induration Date Read:		TST: mm induration Date Read:		
IGRA: Pos Neg Indeterminate Date:		IGRA: Pos Neg Indeterminate Date:		
Chest X-Ray: Date: □Normal □ Abnormal (Stable)		Chest X-Ray: Date: □Normal □ Abnormal (Stable)		
Treatment Completed:	Treatment Completed: Yes No (Contact Provider)			
	ed: #Mos:			#Mos:
	·····			
	Phone:			hone:
			'	

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying

Your TB Test and Treatment Record

Show this card to your health care provider.

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 or Chills, Losing Weight without Trying