Name: ___________________________ DOB: __________
TST: ______ mm induration Date Read: ______________
IGRA: ☐ Pos ☐ Neg ☐ Indeterminate 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: _____________

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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

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