## REPORT OF TUBERCULOSIS SCREENING

DATE ___________________

Name _____________________________________ Date of Birth _____________

**TO WHOM IT MAY CONCERN:**

**The above named individual has been evaluated by _________________________.**
(Name of health dept/facility)

**Tuberculin Skin Test (PPD)**

Date given _______________ Date read _________________

Results : ___________ mm _____ Negative _____ Positive

Signature _____________________________________ Date ________________
(MD or Health Department Official)

Address ______________________________________ Phone _______________

**Chest X-ray Report – No active disease**

Date of Chest x-ray ____________________

_____ No evidence of active tuberculosis

**The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.**

Signature _____________________________________ Date ________________
(MD or Health Department Official)

Address ______________________________________ Phone _______________

**Chest X-ray Report – Abnormal Report**

Date of Chest x-ray ____________________

_____ Chest x-ray abnormal, active tuberculosis to be ruled out

**Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.**

Signature _____________________________________ Date ________________
(MD or Health Department Official)

Address ______________________________________ Phone _______________