

McLaren Print System Order

Order No: 48700 Reprint Previous Order No: 6372
Order Date: 2019-09-18
User: Theda Simmonds
Phone: 989-393-2857

Ship Location: McLaren Occupational and Convenient Care - Bay City
4 Columbus Ave
Bay City, MI. 48708,

Forms

Quantity: 2500
Paragon Dept No: 69100
Dept Name: Occupational Convenient Care
Company Number: 810

Order Total Price: 147.75

Item Number: MM-34220
Item Description: TB Skin Test Documentation Form
Revision Date: 6/2016
Print: 1 sided black and white
Paper: 2 Part (White, Yellow)
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Misc Info:

McLAREN MEDICAL GROUP

2213 E. Hill Rd.
Grand Blanc, MI 48409

1254 N. Main St.
Lapeer, MI 49446

1520 S. Mission St.
Mt. Pleasant, MI 48858

4 Columbus Ave, Suite 140
Bay City, MI 48708

TB SKIN TEST DOCUMENTATION FORM

Patient/Employee Name: _____ Date of birth: _____

Administration

TB Screening Questionnaire completed _____

Brand: _____ Lot#: _____ Exp Date: _____

____ 0.1 mL administered with 6-10mm wheal Arm: Right/Left

Date/Time of administration: _____

Administered By: _____

Reading

Date/Time Read: _____ Read By: _____

Results: _____ mm of induration

Recommendations for results over 0mm of induration:

Provider reviewed results: _____

Provider recommendations: _____

Provider Signature: _____

Positive Skin Test Result

Date/Time Health Department Notified: _____

Reported By: _____

MM-34220-016

McLAREN MEDICAL GROUP

2213 E. Hill Rd.
Grand Blanc, MI 48409

1254 N. Main St.
Lapeer, MI 49446

1520 S. Mission St.
Mt. Pleasant, MI 48858

4 Columbus Ave, Suite 140
Bay City, MI 48708

TB SKIN TEST DOCUMENTATION FORM

Patient/Employee Name: _____ Date of birth: _____

Administration

TB Screening Questionnaire completed _____

Brand: _____ Lot#: _____ Exp Date: _____

____ 0.1 mL administered with 6-10mm wheal Arm: Right/Left

Date/Time of administration: _____

Administered By: _____

Reading

Date/Time Read: _____ Read By: _____

Results: _____ mm of induration

Recommendations for results over 0mm of induration:

Provider reviewed results: _____

Provider recommendations: _____

Provider Signature: _____

Positive Skin Test Result

Date/Time Health Department Notified: _____

Reported By: _____

MM-34220-016