McLAREN MEDICAL GROUP McLAREN MEDICAL GROUP Office Stamp Office Stamp TB SKIN TEST DOCUMENTATION FORM TB SKIN TEST DOCUMENTATION FORM Patient/Employee Name: _____ Date of birth: _____ Patient/Employee Name: _____ Date of birth: _____ Administration Administration TB Screening Questionnaire completed TB Screening Questionnaire completed Brand: Lot#: Exp Date: Brand: Lot#: Exp Date: ____ 0.1 mL administered with 6-10mm wheal Arm: Right/Left ___ 0.1 mL administered with 6-10mm wheal Arm: Right/Left Date/Time of administration: Date/Time of administration: Administered By: _____ Administered By: Reading Reading Date/Time Read: Read By: Date/Time Read: Read By: Results: ____ mm of induration Results: ____ mm of induration Recommendations for results over 0mm of induration: Recommendations for results over 0mm of induration: Provider reviewed results: Provider reviewed results: Provider recommendations: Provider recommendations: Provider Signature: Provider Signature:

Positive Skin Test Result Positive Skin Test Result

Date/Time Health Department Notified: _____ Date/Time Health Department Notified: _____

Reported By: _____

Reported By: