McLAREN MEDICAL GROUP

Office Stamp

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: _____

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