Please have physician fill out bottom portion of the form: or attach a copy from Gannett Health Services.

SKIN TEST FOR TUBERCULOSIS

Name: ___________________________ Date: __________________

Physician: __________________________

Tuberculosis History:

Have you had tuberculosis? Yes_______ No_______ If yes when? ________________
Treatment given________________________

Has anyone in your family or immediate household had TB?

Yes_______ No_________ If yes, relationship:________________________

Have you had a previously “positive” tuberculin skin test?

Yes_______ No_________ If yes, when:_______________________________ and
Did you receive prophylactic treatment? __________________________

Have you had an allergic reaction to testing agents? Yes________ No_________

Have you had a BCG? Yes_______ No_______ If yes, approximate date:___________

SKIN TEST FOR TUBERCULOSIS

Intermediate strength purified protein derivative (PPD) 0.1 cc given intradermal.

Date and time given: __________________________
Test side: __________________________
Given by: __________________________

To be completed by the tuberculin skin test reader: __________________________

Signature of Reader

Date and time read: ________________
Results: ____________________ Negative no indurations (or 0-4mm)
_________________________ Doubtful 5-9 mm (please be specific)
_________________________ Positive 10 mm (please be specific)