EAST STROUDSBURG UNIVERSITY

TB TESTING RESULTS

LAST NAME: FIRST NAME:

BLOOD TEST DATE RESULTS:

DATE READ:

MANUFACTURER NAME: LOT #:

MEDICAL FACILITY:

CONSULTING PRACTITIONER NAME:

CONSULTING PRACTITIONER SIGNATURE:

PHONE #:

TB TINE UPDATE

IF THE CURRENT TB RESULTS ARE OVER 3 MONTHS BUT LESS THAN ONE YEAR, PLEASE ATTEST TO THE FACT THAT ANOTHER TEST WILL NOT BE ADMINISTERED AND THAT THE PATIENT IS CURRENTLY FREE OF TB

COMMENTS:

CONSULTING PRACTITIONER NAME:

CONSULTING PRACTITIONER SIGNATURE:

PHONE #: DATE:

TB X-RAYS RESULTS: **Only necessary if original TB Tine is false positive**

X-RAYS DATE:

X-RAYS RESULTS:

MEDICAL FACILITY: PHONE #: