TB Test Result Form

Name: _____

Social Security Number: _____

To be completed by the Physician:
Name of MD who read the exam (please print): _____

Date TB test was administered: _____

Date TB test result was read:_____

Result of Test: _____Positive _____Negative

Does Patient need to have a chest x-ray? _____Yes _____No

Signature of MD who read the exam: _____

Date:_____

MD Address: _____ MD Phone Number: _____
_____
_____

Please Attach Form Here:

Note: Your physician's office may use its own TB test form to report the results, or you may be submitting results from a TB test administered within the last twelve (12) months. If so, please attach that documentation. Please indicate dates when the test was administered and read.