Report of Tuberculosis Screening Evaluation

Name: _____ Social security number:_____

Birthdate: _____

1. Date and result of most recent Mantoux tuberculin skin test:

   Date: _____
   Result (mm of induration): _____

2. Check here if previously positive and above information unknown: ( )

3. Check here if exhibiting tuberculosis-like symptoms: ( )

4. If tuberculin skin test result is 10 mm or greater, previously positive, or if tuberculosis-like symptoms exist, *respond to the following:*

   a. Date of last chest x-ray evaluation: _____

   b. Is chest x-ray suggestive of active TB? Yes No (*circle one)*

   c. Were sputum smears collected and analyzed for the presence of acid fast bacilli (AFB)? Yes No *(circle one)*

   d. If 4c is answered yes, were three consecutive smears negative for AFB? Yes No *(circle one)*

5. **Based on the above information, is this individual free of communicable TB?**

   Yes No *(circle one)*

6. Signature of licensed physician, physician's designee, or local health department official completing the evaluation:

   _____ _____
   Signature Date

Printed name, address, and phone number of person completing the evaluation.