

Account Number: \_\_\_\_\_

Provider: \_\_\_\_\_

DOS: \_\_\_\_\_

**TO BE COMPLETED BY THE PATIENT**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

HAVE YOU EVER TESTED POSITIVE FOR TB?  YES  NO

HAVE YOU EVER HAD A BCG SHOT?  YES  NO

ARE YOU CURRENTLY TAKING STEROIDS?  YES  NO

I UNDERSTAND I MUST RETURN IN TWO DAYS FOR THE RESULTS OF THE TEST.

\_\_\_\_\_  
Patient's Signature (or parent's)

\_\_\_\_\_  
Date

**Determine below which classification best describes the patient and check the box that matches that description.**

**Patient is type 1:**   
**Positive if induration is  $\geq 5$  mm**  
  
HIV infected persons; had recent contact with a person with TB disease; persons with fibrotic changes on CXR consistent with prior TB; Patients w/organ transplants; persons who are immunosuppressed for any other reason.

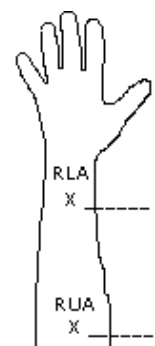
**Patient is type 2:**   
**Positive if –induration is  $\geq 10$  mm**  
Recent immigrants (<5 years) from high-prevalence countries; Injection drug users; Residents and employees of high-risk congregate settings; Mycobacteriology laboratory personnel; Persons with clinical conditions that place them at risk; Children <4 years of age; Infants, children & adolescents exposed to adults in high-risk categories.

**Patient is type 3:**   
**Positive if –induration is  $\geq 15$ mm**  
  
Considered positive in any person, including persons with no known risk factors for TB.

**SKIN TEST RECORD**

**The diameter of the indurated area should be measured across the forearm (Perpendicular to the long axis).**

Administered By:	Admin. Date & Time:	Strength	Dose	Site	Lot# and Exp. Date
_____	_____	_____	_____	_____	_____
Date/Time Reading	Induration mm x mm	Reader's Signature	@ 48 or 72 hrs?		
_____	_____	_____	_____		



**PPD RESULTS:**  POSITIVE  NEGATIVE

**Provider**