TB Test Result Form

Name_____ ID _____

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To be completed by the Health Care Professional (HCP):

Name of HCP who read the exam (please print) _____

Date TB test was administered_____ Date TB test result was read _____

Result of Test _____ Positive _____ Negative

Chest X-ray Needed _____ Yes _____ No

Signature & Credentials of HCP who read exam _____

HCP Address_____ City _____

State/Zip_____ PH _____

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Note: Your HCP'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 below. Please indicate dates when the test was administered and read.

Date Test Administered_____ Date Test Read_____

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Attach TB Results from
Other Source Here