LSU Health NEW ORLEANS

Annual TB Test

House Officer Name:_____ EMPLID:_____

Birthdate:_____ Program:_____

Patient instructed and agrees to return to clinic within 48-72 hours of PPD placement for reading of TB skin test.

_____ _____
(Resident Signature) (Date)

For clinician use only

The results cannot be read by the individual taking the TB test

Results		**Negative**	**Positive**	
☐ PPD*	Date_____	☐	☐	_____*mm*
☐ Chest XRay	Date_____	☐	☐	Attach results
☐ QuantiFERON Gold or T-SPOT	Date_____	☐	☐	Attach results

_____ _____ _____
(Clinician Name) (Signature) (Date)

If Positive Test Result:

1) Date of positive PPD testing: _____
2) Treatment: _____ Dates: _____
3) Chest X-Ray: _____ Dates:_____

Results within past 24 months*
*for incoming HOs, must be within with 6 months of start

_____ _____ _____
(Clinician Name) (Signature) (Date)

Yearly symptom review for all positive testing:

Are you currently experiencing any of the following symptoms:

	Yes	No
Fever	☐	☐
Cough	☐	☐
Recent Weight Loss	☐	☐
Hemoptysis	☐	☐
	☐	☐

House Officer Signature _____

Form and supporting documentation may be submitted online at https://lsuh.sc/msGMESubmit

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