Lutheran HealthCare SM

Date:_____

Tuberculosis Screening Results:

1. Mr./Ms._____

(DOB:_____/_____/_____completed a tuberculin evaluation. He/ She had a positive / negative skin test : _____/_____/_____.

2. Chest X-ray:
   - o Is not needed
   - o Was done on _____/_____/_____
3. Chest X-ray result:
   - o Not applicable
   - o No evidence of active tuberculosis
4. Follow up
   - o Is not needed
   - o Other

_____

(Staff Signature)

_____

(Print Name/ Title)

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