



**This Form MUST Be Completed By
A Medical Professional ONLY**

TB SCREEN

CLIENT NAME: _____

Date of Birth Day _____ Month _____ Year _____

To the Nurse: Please ensure that the following is filled out as completely as possible.
Include copies of any relevant records.

As indicated on the assessment and referral package, TB testing is required before participating in a residential treatment program. Please ensure that TB testing has been completed and that the results are forwarded to the treatment center.

Has a Tuberculosis screening test been done for this client? Yes _____ No _____

Date of test: _____

Results: Negative _____ Positive _____

Chest X-Ray: Yes _____ No _____

Interpretation: _____

Prophylaxis: _____ Date started: _____

Has this client had any or all Hepatitis B Immunizations? Yes _____ No _____

If yes, how many? _____ Next due: _____

Name of Doctor or Nurse Administering Test:

Address of Clinic: _____

Phone # of Clinic: _____

Signature

Date