



STATE OF TENNESSEE  
**DEPARTMENT OF HEALTH**  
TUBERCULOSIS ELIMINATION PROGRAM  
3<sup>rd</sup> FLOOR, ANDREW JOHNSON TOWER  
710 JAMES ROBERTSON PARKWAY  
NASHVILLE, TENNESSEE 37243

## Report of Screening and Testing for Tuberculosis

Resident name: \_\_\_\_\_  
First Name Last Name

This document verifies that the person whose name appears above was formally assessed for risk of TB infection

A TB test was performed on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
The test was a:  TB skin test /  Blood test (QuantIFERON®-TB Gold In-Tube)  
The test result was:  Negative: no further evaluation is necessary.  
 Positive: this person has infection with the bacteria that causes tuberculosis (TB), further evaluation was/is needed.

A chest X-ray was performed on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
The X-ray result was:  Normal  Abnormal

A medical exam was completed on \_\_\_\_/\_\_\_\_/\_\_\_\_.  
The exam result was:  Normal  Abnormal

Diagnosis:  Active TB  TB Infection (TBI)  No TB/TBI

Medication Taken:  Yes  No Treatment Complete:  Yes  No

Treatment Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Treatment Stop Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Medication Taken: \_\_\_\_\_

Staff Name: \_\_\_\_\_  
Provider Name (print) Title  
\_\_\_\_\_  
Signature Date

Facility: *[Insert name of county health department,  
Clinic name  
Facility street address  
City, state, zip code  
Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_]*