



2812 Old Lee Highway
Suite 210
Fairfax, VA 22031
Voice (703) 204-4664
Fax (703) 204-0509
www.alzheimersfdc.org

Report of Tuberculosis Screening

Date _____

Name _____

Date of Birth _____

To Whom It May Concern:

The above named individual has been evaluated by _____.
(Name of health dept/facility)

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_____ The individual either is currently receiving or has completed adequate modification for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_____ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature _____
(MD or Health Department Official)

Date _____

Address: _____

Phone _____



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To Whom It May Concern:

The above named individual has been evaluated by _____.
(Name of health dept/facility)

Tuberculin Skin Test (PPD)

Date Given _____ Date Read _____

Results: _____ mm _____ Negative _____ Positive

Signature _____ Date _____
(MD or Health Dept. Official)

Address _____ Phone _____

Chest X-ray Report – No Active Disease

Date of chest x-ray _____

_____ No evidence of active tuberculosis

The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Dept. Official)

Address _____ Phone _____

Chest X-Ray Report – Abnormal Report

Date of chest x-ray _____

_____ Chest X-ray abnormal, active tuberculosis to be ruled out

Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.

Signature _____ Date _____
(MD or Health Dept. Official)

Address _____ Phone _____