TO: ___________________________  D.O.B. ___________________________

TB skin test reading or verified history:

X-ray results:

Preventive therapy: Yes ____ No ____  If no, reason: _______________________________

Therapy completed: _______________________________

Active case: Treated from ____________ to ____________.

Sputums negative since: ____________  Therapy completed: _______________________________

If the following symptoms should occur, please contact your private physician or the county health department:

1. productive cough  2. bloody sputum  3. night sweats
4. loss of appetite  5. unusual tiredness  6. weight loss
7. low-grade fever

The above client should not receive another TB skin test for the remainder of their lifetime, and only needs a repeat chest x-ray if having any of the above symptoms.

Any County Health Department
Any Street
Anywhere, Kansas 00000
(000) 000-0000