Tuberculosis Skin Test Form

Healthcare Professional/Patient Name: _____

Testing Location: _____

Date Placed: _____

Site: ☐ **Right** ☐ **Left**

Lot #: _____ **Expiration Date:** _____

Signature (administered by): _____

☐ **RN** ☐ **MD** **Other:** _____

Date Read (within 48-72 hours from date placed): _____

Induration (please note in mm): _____ **mm**

PPD (Mantoux) Test Result: ☐ **Negative** ☐ **Positive**

Signature (results read/reported by): _____

☐ **RN** ☐ **MD** **Other:** _____

***In order for this document to be valid/acceptable, all sections of this form must be completed.**

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