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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