MARTINEZ URGENT CARE

210 Bobby Jones Expressway
Martinez, GA 30907
(706) 855-1755

TB TEST CERTIFICATION

Date ____/____/____

Name _____ SS#_____

Medical History/Risk Assessment:

- Have you ever had a positive reaction to a TB skin test? _____
- Since your last TB skin test have you experienced any of the following symptoms for more than three weeks at a time?

Excessive sweating at night Yes__ No__
Excessive weight loss Yes__ No__
Coughing up blood Yes__ No__
Excessive fatigue Yes__ No__
Hoarseness Yes__ No__
Persistent coughing Yes__ No__
Persistent fever Yes__ No__

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Mantoux Tuberculin Test Placement
0.1ml purified protein derivative (PPD)

Manufacturer's Name_____
Lot #_____
Expiration Date_____

Left inner forearm_____ Right inner forearm_____

Administered by_____ Date____/____/____ Time_____

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Date read____/____/____ Time_____

Induration (mm)_____ Negative_____ Positive_____

Read By_____