TUBERCULOSIS CLINIC PATIENT RECORD

TO:____ D.O.B. ____________________________

TB skin test/IGRA blood test result or verified history:

1 Step TST   2 Step TST   QFT   T-Spot   History

TST: _________ mm TST: __________ mm QFT: ______ T-Spot: ______

X-ray results:

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

Preventative therapy completed: Yes   No

If Yes, Date of completion: _____________

Active case: Treated from _________________________ to ______________________________.

Sputum smear negative since: ______________________________

Therapy completed: Yes   No

If Yes, Date of completion: _____________

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 or blood test (IGRA/QFT/T-Spot) for the remainder of their lifetime, and only needs a repeat chest x-ray if having any of the above symptoms.