



iCare Health Services
HealthCARE on the go!

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TB test Results Form

Name: _____ DOB: _____

The following must be completed by a physician's office:

- Tuberculin Skin Test (Mantoux only; no tine tests)
- Must be completed within 12 months prior to the start of classes.

Date given: ____/____/____ Location: _____ Time: _____

Date read: ____/____/____ Time: _____ Result: _____ mm (record in actual mm of induration. If no induration, write "0".) Interpretation (based on mm of induration as well as risk factors):

Positive____ Negative____

OR –

T-spot lab test_____

Must be completed within 12 months prior to the start of classes.

Date of test: ____/____/____ Result: _____

- If either TB skin test or T-spot lab test are positive, then a chest x-ray is required:

Chest x-ray results: Normal_____ Abnormal_____

Date of chest x-ray: ____/____/____

Physician or Nurse Signature

Date

Official Office Stamp

**Note: Your physician's office may use its own TB test form to reports results, or you may be submitting results from a TB test administered within the last 12 months. If so, please attach that documentation. Please indicate dates when the test was administered and read.*