POSITIVE REACTOR STATUS REPORT

MUST BE <u>COMPLETED</u> AND <u>SUBMITTED</u> WITH TB
EVALUATION CLEARANCE FORM **ONLY** IF THE PPD SKIN TEST IS POSITIVE

NAME ______________________________ DOB _______-_______-_______

ADDRESS ______________________________ ETHNICITY _______________

PHONE(Home/Work):_______________/_______________

1. PPD Test: Date Given: ______ Date Recd: _____ Results: ____ mms

2. Chest X-Ray: Date __________ Normal _____ Abnormal _____
   ** NOTE: Radiological Interpretation by Licensed Radiologist Must be attached.*

3. INH Preventive Therapy Offered: Yes _____ No ______

4. Patient is currently on INH Preventive Therapy at my clinic.

   Yes ______ No ______ Date Preventive Therapy Started:_____________

5. If not on INH Preventive Therapy, please state reason:

   ___ a. Patient refuses INH Preventive Therapy offered.
   ___ b. Patient is over 35 years of age with no risk factor.
   ___ c. Other (Specify) ______________________________

6. Patient cleared for work/School: Yes ______ No ______

7. Patient referred to DPHSS Communicable Disease Control Clinic for possible INH Preventive Therapy.

   Yes ______ No ______

8. Patient referred to DPHSS Communicable Disease Control Clinic for possible active TB.

   Yes ______ No ______

9. Comments:____
   ____

______________________________ ______________________
Physicians' Signature Date

____
Name of Physician/Clinic (print)

BCDCADMIN/TBPRSR(8/4/95)