

POSITIVE REACTOR STATUS REPORT

MUST BE COMPLETED AND SUBMITTED 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)