Please fax to:
519-376-4152

Postive TB Skin Test Report Form

Grey Bruce Health Unit
Infectious Diseases Program

From: _____ Date: _____

Phone: _____

Please complete/confirm demographics:

Patient first name: _____ Patient last name: _____

Date of Birth: _____ Family Health Care Provider: _____

Phone number: _____ Reason for testing: _____

Results:

TB Skin Test #1

Date Seeded: _____
Date Read: _____
Result: _____
Lot #: _____

TB Skin Test #2

Date Seeded: _____
Date Read: _____
Result: _____
Lot #: _____

Chest X-Ray Results: _____

Please fax a copy of the report to 519-376-4152

Have you informed the client a Public Health Nurse will be contact them? ☐Yes ☐No

Signature: _____ Date: _____

Personal information contained on this form is collected under the authority of the Health Protection and Promotion Act and is used to follow infectious diseases case investigations and statistical purposes.