



**TB SCREENING  
SKIN TEST  
PROTOCOL**

Name: \_\_\_\_\_

Last 4 SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Department: \_\_\_\_\_

Date of Service: \_\_\_\_\_

Contracted Clinic: \_\_\_\_\_

**COMMENTS:** Administer your clinic's standard TB screening questionnaire. Triage as "No Restrictions" unless x-ray is suggestive of active TB. Employees with active TB will need to be restricted immediately and referred for treatment.

**PACKAGE: TB SCREENING – SKIN TEST**

I01

\_\_\_\_\_ Review TB questionnaire  
\_\_\_\_\_ PPD (unless history of positive PPD)

**ADDITIONAL TESTING:**

**Today:**

(+) PPD or (+) IGRA in past and (+) TB symptoms now	➤ _____ Chest x-ray, PA, with read	A11
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**48-72 Hours Later:**

PPD ≥ 5mm and employee is immuno-suppressed or compromised	➤ _____ Chest x-ray, PA, with read	A11
PPD ≥ 10mm	➤ _____ Chest x-ray, PA, with read	A11

*I certify the above referenced tests were performed and completed on the applicant listed above.*

**Authorized Clinic Representative:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_