BROWN

Health Services
Box 1928
Providence, RI 02912
401-863-3953

To return form, student must log in at https://brown.medicatconnect.com and upload.

Tuberculosis (TB) Screening Documentation Form

Name _____ Date of Birth ____/____/____
Last First Middle mm dd yy

Address _____
Street City State Zip Code Country

TB (Tuberculin) Skin Test
Must be performed in the U.S. (If you are unable to have the test done in the U.S., you will need a TB skin test at Brown Health Services.)

Date TB skin test given: _____ Date TB skin test read (must be read in 48-72 hours): _____

Results (must be recorded in mm of induration; if no induration, write "0") _____mm

IGRA (QuantiFERON Gold, T-SPOT)
Worldwide testing acceptable

Date of test: _____ ❒ QuantiFERON Gold ❒ T-SPOT

Result: ❒ Positive ❒ Negative ❒ Indeterminate

Chest X-ray (Required if tuberculosis test is positive)

Date: _____

Result: ❒ Normal ❒ Abnormal

Dates of Treatment for latent or active TB: _____

Treatment Medication: _____

Signature of Physician / Medical Provider: _____ Date: _____

Physician / Medical Provider Name: (Please Print) / Clinic Stamp _____

Address _____

Phone number: _____ Fax Number: _____