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

To return form, student must log in at https://patientportal.brown.edu 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

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)

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: _____