LSU STUDENT HEALTH SERVICES
2020 GRAVIER ST., 7TH FLOOR
NEW ORLEANS, LA 70112
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Annual TB Skin Test

Name_____
Last First

DOB_____

Program AH DS GS MED NUR

_____

_____

_____

Patient instructed and agrees to return to clinic within 48-72 hours for reading of TB skin test_____
Initial here

For office use only

Result **NEG@_____mm** **POS@_____mm** _____ _____
Date **Initial**

☐ **CXR** **Neg** **Pos**

☐ **INH** ☐ **Student Health to manage INH**

☐ **Wetmore to manage INH**

☐ **TB sx discussed w/pt**