San Fernando Pediatrics & Urgent Care

107 N Maclay Ave, San Fernando, CA 91340
Tel: (818) 697-8585 Fax: (888) 799-8585

TB (PPD) SKIN TEST

Patient's Name: _____ DOB: _____ Age: _____

DATE GIVEN: _____

SITE: _____LEFT FOREARM _____RIGHT FOREARM

I, _____, UNDERSTAND THAT I MUST RETURN TO THIS OFFICE BETWEN 48 TO 72 HOURS AFTER RECEIVING THIS TEST OR IT WILL BE INVALID AND WILL HAVE TO BE REPEATED AND I WILL HAVE TO PAY AGAIN. TESTS CAN'T BE READ BEFORE 48 HOURS OR AFTER 72 HOURS EVEN BY ONE MINUTE.

SIGNATURE OF THE PATIENT: _____ DATE: _____

DATE READ: _____ INDURATION (MM): _____

RESULTS: _____

PHYSICIAN SIGNATURE & STAMP: _____

X-RAY DATE: _____

RESULT: _____

PHYSICIAN SIGNATURE & STAMP: _____