RSN PPD RECORD FORM

Patient Information

Full Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Telephone: _____ _____Cell:

_____

Skin Test Information

Administrator Name/Title: _____

Date/time Administered: _____

Manufacturer of PPD Solution: _____

Expiration Date of PPD Solution: _____

Lot #: _____

PPD Administration Location: (Circle one) R Forearm L Forearm

Results

Induration: _____mm Date/Time of Reading: _____

Comments and Adverse Reaction(s), if any: _____

_____

Name and Title (MD/RN/LPN) of Reader: _____

HealthCare Provider Signature: _____ Date: _____/_____/_____