Name: DOB: | |

TST: | | ____ mm induration Date Read: | |

IGRA: ❑ Pos ❑ Neg ❑ Indeterminate Date: | |

Chest X-Ray: Date: | | ❑ Normal ❑ Abnormal (Stable)

Treatment Completed: ❑ Yes ❑ No (Contact Provider)

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Provider Name:

Signature: Phone: ( )

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YOUR TB TEST AND TREATMENT RECORD

- Keep this card in your wallet at all times
- Show this card to the doctor, so you don't get tested and/or treated again
- Call your doctor if you have any signs or symptoms of TB disease for 2 or more weeks:

- Cough	- Feeling weak and tired
- Chest pain	- Fever and chills
- Coughing up blood	- Night sweats
- Losing weight without trying	

West Virginia Department of Health

WV TB Elimination Program 1-800-330-8126

TB-60 Oct 2024

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