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)
Name of Drug(s):
Started: | | Stopped: | | # Wks.:
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 and Human Resources
Division of Tuberculosis Elimination 1-800-330-8126
TB-60 (R-2012) www.dhhr.wv.gov/oeps/tuberculosis

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