

WINGS
1326 East Ripley St.
Litchfield, MN 55355

MANTOUX TEST VERIFICATION

Patient Name: _____ Date _____

Patient states he/she has had previous mantoux

Yes ____ No ____ Unsure _____

If yes, Has it been Positive _____ Negative _____

If positive: Dr. _____ Notified date: _____ Time: _____

Mantoux held _____ Nurse Signature: _____

Mantoux was given on _____ Time: _____ a.m. p.m.

In right forearm _____ Left forearm _____

Nurse Signature: _____

Results after ____ hours Negative Positive

Nurse Signature

FREE OF COMMUNICABLE DISEASE STATEMENT

Date: _____

To the best of my knowledge, the above stated patient is apparently free of communicable diseases.

Doctor Signature: _____