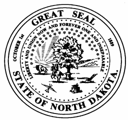

TUBERCULIN TEST REGISTRATION
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 7722 (Rev. 12-02)
Report positive results only. Complete entire card.
Indicate not applicable or unknown where appropriate.

Person Completing Card
Facility
Phone #

Name (Last, First, MI) | Phone (H) (W)
Address | Date of Birth | ❒ Male ❒ Female
City, State, Zip | Race/Ethnicity | Marital Status
Reason for Test (employment, refugee, etc.) | Former TB Client? ❒ No ❒ Yes | Previous Reactor? ❒ No ❒ Yes | Date of Previous Test
Date of Test 1 | Date Read | Results MM | X-ray Date (within 2 wks of positive test, if possible) | X-ray Results | Treatment ❒ No ❒ Yes
Date of Test 2 (if 2-step) | Date Read | Results MM | Treatment Start Date | Facility/Unit Monitoring Treatment
Medication Prescribed | Length of Treatment | If No Treatment, Reason for Not Treating
Name of Physician | Phone Number | Address

Send original to N.D. Dept. of Health, Division of Disease Control, 600 E. Boulevard Ave., Bismarck, N.D. 58505-0200.
If you have questions, call 1.800.472.2180.

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This side for N.D. Department of Health use.

Reason for Treating ❐ Converter ❐ Reactor ❐ Contact		If Refugee, Year of Entry/EpiID		Date Closed	Reason Closed
Refill Date	**Number of Doses Given**	**Refill Date**	**Number of Doses Given**	**Refill Date**	**Number of Doses Given**

Comments:

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Reason for Treating ❐ Converter ❐ Reactor ❐ Contact		If Refugee, Year of Entry/EpiID		Date Closed	Reason Closed
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Comments:

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Refill Date	**Number of Doses Given**	**Refill Date**	**Number of Doses Given**	**Refill Date**	**Number of Doses Given**

Comments: