



**TUBERCULIN TEST REGISTRATION
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL**

SFN 7722 (Rev. 08-10)

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	<input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, Zip		Race/Ethnicity	Country of Birth
Reason for Test (employment, refugee, etc.)	Former TB Client? <input type="checkbox"/> No <input type="checkbox"/> Yes	Previous Reactor? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of Previous Test
Date TST Planted	Date Read	Results MM	X-ray Date (within 2 wks of positive test, if possible)
		X-ray Results	Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes
Date of IGRA	Name of Test	Results	Treatment Start Date
		Facility Monitoring Treatment	
Medication Prescribed		Length of Treatment Months	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, 2635 E. Main Ave., P.O. Box 5520, Bismarck, N.D. 58506-5520. 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 <input type="checkbox"/> Converter <input type="checkbox"/> Reactor <input type="checkbox"/> Contact		If Refugee, Year of Entry		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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Comments: