

AUBURN UNIVERSITY MEDICAL CLINIC
TUBERCULIN TESTING

Name _____ Date of Birth _____

AUBURN Email: _____ AUBURN ID #: _____

Type of Test:

TB Blood Test: Date Drawn: _____

T-Spot QuantiFERON Gold

Results: Negative Positive

TB Skin Test: Date Given: _____ Date Read: _____

PPD Intermediate Skin Test Left Arm Right Arm

Results: _____ mm Negative Positive

(Must be read NO EARLIER than 48 hours, NO LATER than 72 hours)

****PLEASE NOTE – A Chest X-RAY is no longer accepted****

Location or Stamp of Test Administered:

Signature of Person Reading Results

Date

RESULTS MAY BE EMAILED OR FAXED TO:

Email: aumcmedrecords@eamc.org

Fax: 334-528-5416