California Foster Families, Inc.

www.cafosterfamilies.com

TB TEST RESULTS/AMBULATORY STATUS

Patient's Name:_____

Date Test Given:_____

Date Test Read:_____

_____Positive

Action Taken if Positive:_____

_____

_____

_____Negative

Comments:_____

_____

_____

I certify that the aforementioned child is:

( ) Ambulatory ( ) Non-Ambulatory

Name of Clinic: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

_____ _____

Signature of Physician Date

09/2014

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