TROCAIRE COLLEGE

Tuberculin Skin Test (TST) Record Form

Patient Information

Name: _____

Address: _____

Skin Test Information

Administrator Name: _____

Date/time Administered: _____

Arm on which Administered: _____

Manufacturer of TST Solution: _____

Expiration Date of TST Solution: _____

Lot #: _____

Results

Induration: _____mm Date/time of Reading: _____

Comments and Adverse Reaction(s), if any*: _____

_____

Name of Reader: _____

Signature: _____

*************If TST 15mm or greater a copy of a chest x-ray is required*************

MAIN CAMPUS
360 Choate Avenue
Buffalo, NY 14220
716-826-1200

2262 Seneca Street
Buffalo, NY 14210
716.826.1200

EXTENSION CENTER
6681 Transit Road
Williamsville, NY 14221
716-827-4300