Shenandoah Univeristy
Wilkins Wellness Center
Tuberculosis-Statement of Treatment

Date: _________________

Dear Provider,

____________________________________ will be providing patient care to comply with the clinical experience requirements. A chest x-ray was completed on _____/_____/_____ due to a Tuberculin Skin Test result measuring: __________ mm. (See attached CXR)

☐ ***Free of Active Disease or Determined to have Latent TB***

My patient, named above, has been examined for Pulmonary Tuberculosis (TB) and is free of active disease. The patient has been counseled on the risk of developing Pulmonary TB and risks that the patient may pose to their contacts. The patient has been instructed on signs and symptoms of Pulmonary TB and to seek medical evaluation should they become symptomatic.

Placed on Treatment Therapy for Latent TB: _____ **No** _____ **Yes** **Rx:** ___________________________________

Follow-up appointment date: _______________

Return to school/clinical status _____ **May** return to full duty as of:

☐ ***Current Diagnosis of Active Disease***

Placed on Treatment Therapy: _____ **No** _____ **Yes** **Rx:** ____

Follow-up appointment date: ______________

Return to school/clinical status _____ **May not** return to school/clinical at this time due to current diagnosis of "active Tuberculosis."

☐ ***Treatment of Active Disease***

I attest that I am a healthcare provider qualified to make the determination that this patient is no longer infectious by demonstrating sputum is free of bacilli on three (3) consecutive smears on separate days or sputum cultures show no growth.

Return to school/clinical status _____ **May** return to school/clinical full duty as of: _____________________

Comments: ____

____ ________________________________
Provider signature **Date**

____
Provider printed name, address, and phone number