HILTON EAST
Assisted Living Community

Physician: _____

Resident: _____ DOB: _____

**In order to remain in compliance with New York State Department of Health Regulations, please complete one of the choice below regarding the above named patient /resident.**

**PHYSICIAN STATEMENT**

The resident named above, is known to me. Based on past medical history and physical examination active tuberculosis infection has been ruled out. In my medical opinion, this resident does not require a Tuberculosis skin test (TST) / Mantoux test / PPD test.

_____ _____

**Physician Signature** **Date**

**PHYSICIAN STATEMENT**

A tuberculosis skin test (TST) / PPD/ Mantoux test has been performed.

Date placed: ___/____/____ Area of PPD _____ Lot # _____ Exp: _____

Signature: _____

Date read: ___/____/____ Results_____

Signature: _____ Title: _____

**Do you as the PCP recommend a second TST/PPD within 30 day after admission?**

**____ Yes ____ No**