HILTON EAST
Assisted Living Community

Physician: _____

Resident: _____ DOB: _____

In order to remain in compliance with New York State Department of Health Regulations, please <u>complete ONE</u> of the choices below regarding the above-named patient /resident for PPD test. The PPD test must be completed <u>within 30 days of the admission date.</u>
And complete the Covid vaccination at the bottom.

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: _____

_____ _____
Physician Signature Date

** COMPLETE THIS BOX ONLY IF POSITIVE RESULT **

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**

Do you as the PCP recommend a second TST/PPD within 30 day after admission? ____ Yes ____ No

COVID Information

Covid -19 Vaccination ____ Yes ____ No Manufacture _____

Dose 1: Date_____ Lot#_____ Administered_____

Dose 2: Date_____ Lot#_____ Administered_____

Dose 3: Date_____ Lot#_____ Administered_____

Dose 4: Date_____ Lot#_____ Administered_____