



TUBERCULOSIS INFECTION REPORT CARD
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL

SFN 7722 (Rev. 10-17)

Report positive results only. Complete entire card.
 Indicate not applicable or unknown where appropriate.

Person Completing Card
Facility
Phone #

Name (Last, First, MI)			Phone (H) (W)		
Address			Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	
City, State, Zip			Race/Ethnicity	Country of Birth	
Reason for Test (employment, refugee, etc.)		Former TB Client? <input type="checkbox"/> No <input type="checkbox"/> Yes	Previous Reactor? <input type="checkbox"/> No <input type="checkbox"/> Yes	Date of Previous Test	
Date TST Planted	Date Read	Results MM	X-ray Date (within 2 wks of positive test, if possible)	X-ray Results	Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes
Date of IGRA	Name of Test	Results	Treatment Start Date	Facility Monitoring Treatment	
Medication Prescribed		Length of Treatment Months	If No Treatment, Reason for Not Treating		
Name of Physician Phone Number Address					

Send original to N.D. Dept. of Health, Division of Disease Control, 2635 E. Main Ave., P.O. Box 5520, Bismarck, N.D. 58506-5520. If you have questions, call 1.800.472.2180.