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	☐ Male ☐ Female
City, State, Zip		Race/Ethnicity	Country of Birth
Reason for Test (employment, refugee, etc.)	Former TB Client? ☐ No ☐ Yes	Previous Reactor? ☐ No ☐ 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 ☐ No ☐ 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.