



# Ages & Stages Questionnaires®

## 6 Month Questionnaire

5 months 0 days through 6 months 30 days



Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: \_\_\_\_\_

### Baby's information

Baby's first name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Baby's last name: \_\_\_\_\_

Baby's date of birth: \_\_\_\_\_ If baby was born 3 or more weeks prematurely, # of weeks premature: \_\_\_\_\_

Baby's gender:  Male  Female

### Person filling out questionnaire

First name: \_\_\_\_\_ Middle initial: \_\_\_\_\_ Last name: \_\_\_\_\_

Street address: \_\_\_\_\_ Relationship to baby:  Parent  Guardian  Teacher  Child care provider

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ ZIP/Postal code: \_\_\_\_\_

Country: \_\_\_\_\_ Home telephone number: \_\_\_\_\_ Other telephone number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Names of people assisting in questionnaire completion: \_\_\_\_\_

### Program Information

Baby ID #: \_\_\_\_\_ Age at administration in months and days: \_\_\_\_\_

Program ID #: \_\_\_\_\_ If premature, adjusted age in months and days: \_\_\_\_\_

Program name: \_\_\_\_\_



# 6 Month Questionnaire

5 months 0 days  
through 6 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

### Important Points to Remember:

- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by \_\_\_\_\_.

### Notes:

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## COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make high-pitched squeals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When playing with sounds, does your baby make grunting, growling, or other deep-toned sounds?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. If you call your baby when you are out of sight, does she look in the direction of your voice?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When a loud noise occurs, does your baby turn to see where the sound came from?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___


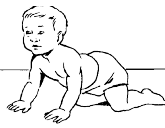
COMMUNICATION TOTAL \_\_\_\_\_

## GROSS MOTOR


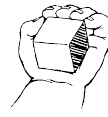

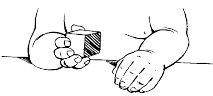
	YES	SOMETIMES	NOT YET	
1. While your baby is on his back, does your baby lift his legs high enough to see his feet?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on her tummy, does she straighten both arms and push her whole chest off the bed or floor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby roll from his back to his tummy, getting both arms out from under him?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. When you put your baby on the floor, does she lean on her hands while sitting? <i>(If she already sits up straight without leaning on her hands, mark "yes" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___



**GROSS MOTOR** *(continued)*

	YES	SOMETIMES	NOT YET	
5. If you hold both hands just to balance your baby, does he support his own weight while standing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby get into a crawling position by getting up on her hands and knees?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
<b>GROSS MOTOR TOTAL</b>				___


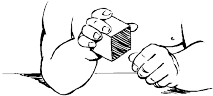

**FINE MOTOR**

	YES	SOMETIMES	NOT YET	
1. Does your baby grab a toy you offer and look at it, wave it about, or chew on it for about 1 minute?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. Does your baby reach for or grasp a toy using both hands at once?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby reach for a crumb or Cheerio and touch it with his finger or hand? <i>(If he already picks up a small object the size of a pea, mark "yes" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
4. Does your baby pick up a small toy, holding it in the center of her hand with her fingers around it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
5. Does your baby try to pick up a crumb or Cheerio by using his thumb and all of his fingers in a raking motion, even if he isn't able to pick it up? <i>(If he already picks up the crumb or Cheerio, mark "yes" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
6. Does your baby pick up a small toy with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
<b>FINE MOTOR TOTAL</b>				___

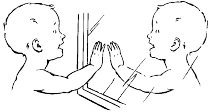



**PROBLEM SOLVING**

	YES	SOMETIMES	NOT YET	
1. When a toy is in front of your baby, does she reach for it with both hands?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. When your baby is on his back, does he turn his head to look for a toy when he drops it? <i>(If he already picks it up, mark "yes" for this item.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. When your baby is on her back, does she try to get a toy she has dropped if she can see it?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

**PROBLEM SOLVING** (continued)

	YES	SOMETIMES	NOT YET	
4. Does your baby pick up a toy and put it in his mouth? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. Does your baby pass a toy back and forth from one hand to the other? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby play by banging a toy up and down on the floor or table? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PROBLEM SOLVING TOTAL				—

**PERSONAL-SOCIAL**

	YES	SOMETIMES	NOT YET	
1. When in front of a large mirror, does your baby smile or coo at herself? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
2. Does your baby act differently toward strangers than he does with you and other familiar people? <i>(Reactions to strangers may include staring, frowning, withdrawing, or crying.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
3. While lying on her back, does your baby play by grabbing her foot? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
4. When in front of a large mirror, does your baby reach out to pat the mirror? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
5. While your baby is on his back, does he put his foot in his mouth? 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby try to get a toy that is out of reach? <i>(She may roll, pivot on her tummy, or crawl to get it.)</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
PERSONAL-SOCIAL TOTAL				—

**OVERALL**

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain:

YES

NO

2. When you help your baby stand, are his feet flat on the surface most of the time?  
If no, explain:

YES

NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

YES

NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

YES

NO

5. Do you have concerns about your baby's vision? If yes, explain:

YES

NO

6. Has your baby had any medical problems in the last several months? If yes, explain:

YES

NO

7. Do you have any concerns about your baby's behavior? If yes, explain:

YES

NO

8. Does anything about your baby worry you? If yes, explain:

YES

NO



# 6 Month ASQ-3 Information Summary

5 months 0 days through  
6 months 30 days

Baby's name: \_\_\_\_\_ Date ASQ completed: \_\_\_\_\_

Baby's ID #: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Administering program/provider: \_\_\_\_\_ Was age adjusted for prematurity when selecting questionnaire?  Yes  No

**1. SCORE AND TRANSFER TOTALS TO CHART BELOW:** See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	29.65		●	●	●	●	●	●	●	○	○	○	○	○	○
Gross Motor	22.25		●	●	●	●	●	○	○	○	○	○	○	○	○
Fine Motor	25.14		●	●	●	●	●	○	○	○	○	○	○	○	○
Problem Solving	27.72		●	●	●	●	●	○	○	○	○	○	○	○	○
Personal-Social	25.34		●	●	●	●	●	○	○	○	○	○	○	○	○

**2. TRANSFER OVERALL RESPONSES:** Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- |  |            |           |  |            |    |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?<br>Comments:    | Yes        | <b>NO</b> | 5. Concerns about vision?<br>Comments:   | <b>YES</b> | No |
| 2. Feet are flat on the surface most of the time?<br>Comments: | Yes        | <b>NO</b> | 6. Any medical problems?<br>Comments:    | <b>YES</b> | No |
| 3. Concerns about not making sounds?<br>Comments:              | <b>YES</b> | No        | 7. Concerns about behavior?<br>Comments: | <b>YES</b> | No |
| 4. Family history of hearing impairment?<br>Comments:          | <b>YES</b> | No        | 8. Other concerns?<br>Comments:          | <b>YES</b> | No |

**3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP:** You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the  area, it is above the cutoff, and the baby's development appears to be on schedule.  
If the baby's total score is in the  area, it is close to the cutoff. Provide learning activities and monitor.  
If the baby's total score is in the  area, it is below the cutoff. Further assessment with a professional may be needed.

**4. FOLLOW-UP ACTION TAKEN:** Check all that apply.

- Provide activities and rescreen in \_\_\_\_\_ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): \_\_\_\_\_
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): \_\_\_\_\_

**5. OPTIONAL:** Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

**STAGES OF HEARING, LANGUAGE,  
AND SPEECH DEVELOPMENT  
FROM BIRTH TO 5 YEARS CHECKLIST**

**Please use this checklist!** Look at your checklist often. Find your child's age level. Check Yes or No for every item. If your child does not pass any two items within an age level, call your doctor to make an appointment.

Age Level	Hearing and Understanding	Check One	Speech	Check One
Birth to 3 months	<ul style="list-style-type: none"> <li>Gives a startle response to loud, sudden noises within 3 feet.</li> <li>Calms to a familiar, friendly voice.</li> <li>Wakes up when you speak or make noise nearby.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Coos and gurgles.</li> <li>Laughs and uses voice when playing.</li> <li>Watches your face when spoken to.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3 to 6 months	<ul style="list-style-type: none"> <li>Looks to see where sounds come from.</li> <li>Becomes frightened by an angry voice.</li> <li>Smiles when spoken to.</li> <li>Likes to play with toys or objects that make noise.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Babbles (uses a series of sounds).</li> <li>Makes at least 4 different sounds when using his or her voice.</li> <li>Babbles to people when they speak.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6 to 9 months	<ul style="list-style-type: none"> <li>Turns and looks to you when you are speaking in a quiet voice.</li> <li>Waves when you say "bye-bye."</li> <li>Stops for a moment when you say "no-no."</li> <li>Looks at objects or pictures when someone talks about them.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Babbles using "song-like tunes."</li> <li>Uses voice to get your attention instead of crying.</li> <li>Uses different sounds and appears to be naming things.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9 to 12 months	<ul style="list-style-type: none"> <li>Points to or looks at familiar objects or people when asked to.</li> <li>Looks sad when scolded.</li> <li>Follows directions ("Open your mouth," "Give me the ball").</li> <li>"Dances" and makes sounds to music.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Uses jargon (appears to be talking).</li> <li>Uses consonant sounds like b, d, g, m, and n when talking.</li> <li>Jabbers in response to a human voice, changes loudness of voice, and uses rhythm and tone.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>NOTE: Be aware that babies between 12 to 15 months old say their first true words.</b>				
12 to 18 months	<ul style="list-style-type: none"> <li>Points to body parts (hair, eyes, nose, mouth) when asked to.</li> <li>Brings objects to you when asked.</li> <li>Hears and identifies sounds coming from another room or from outside.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Gives one-word answers to questions.</li> <li>Imitates many new words.</li> <li>Uses words of more than one syllable with meaning ("bottle").</li> <li>Speaks 10 to 20 words.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>
18 to 24 months	<ul style="list-style-type: none"> <li>Understands simple "yes/no" questions.</li> <li>Understands simple phrases with prepositions ("in the cup").</li> <li>Enjoys being read to and points to pictures when asked.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Uses his or her own first name.</li> <li>Uses "my" to get toys and other objects.</li> <li>Tells experiences using jargon and words.</li> <li>Uses 2-word sentences like "my shoes," "go bye-bye," "more juice."</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Flip chart over to see the checklist for 24 months to 5 years of age. ►



# HEARING CHECKLIST FOR PARENTS

(continued from the other side)

Age Level	Hearing and Understanding	Check One	Speech	Check One
24 to 30 months	<ul style="list-style-type: none"> <li>Understands negative statements (“no more,” “not now”).</li> <li>Selects objects according to size (big, little).</li> <li>Follows simple directions (“Get your shoes and socks”).</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Answers questions (“What do you do when you are sleepy?”).</li> <li>Uses plural words (2 books, dogs).</li> <li>Speaks 100 to 200 words.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>
30 to 36 months	<ul style="list-style-type: none"> <li>Understands uses of objects (“Show me what goes on your foot”).</li> <li>Understands the concept of one and can hand you one of something (1 ball, 1 cookie).</li> <li>Correctly identifies boys and girls.</li> <li>Understands many action words like “run” or “jump.”</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Uses question forms correctly (who? what? where? when?).</li> <li>Uses negative forms (“It is not,” “I can’t”).</li> <li>Relates experiences using 4- to 5-word sentences.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3 to 4 years	<ul style="list-style-type: none"> <li>Understands “why” questions (“Why do you wash your hands?”).</li> <li>Understands opposites like “fast” or “slow.”</li> <li>Correctly selects objects according to color.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Uses different forms of action words (“I play,” “I want to play,” “We played”).</li> <li>Counts to 10.</li> <li>Tells you about pictures in books or about a drawing (“I made a purple flower”).</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4 to 5 years	<ul style="list-style-type: none"> <li>Understands size comparisons (big, bigger, biggest).</li> <li>Understands many pronouns (“Give it to her,” “Give it to him”).</li> <li>Follows a 2- to 3-step command (“Go to the kitchen, get a cup, put it on the table”).</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>	<ul style="list-style-type: none"> <li>Speaks at least 1,500 words.</li> <li>Says most sounds correctly except possibly “s” and “th.”</li> <li>Talks freely to family and friends using full sentences that most people can understand.</li> </ul>	Yes <input type="checkbox"/> No <input type="checkbox"/>

## Do you hear me?

This may be the most important question you ever answer for your baby.

- Babies learn to talk during their first years. Words help them share thoughts and feelings with the important people in their world.
- As your baby hears words, language and learning begin and speech develops.
- The checklist above and on the other side shows you how learning helps the speech development of your child.
- Watch your child grow through stages of normal hearing and speech development. Seek help immediately if your child is not developing according to the checklist.

## What can you do?

- Some infants are born with normal hearing and later become deaf or hard of hearing. That is why you must continue to fill out the checklist.
- If you think your child has a hearing problem, **do not delay**. Seek help **immediately**.

## NOW...

- You know your child best. If you suspect a possible hearing loss, talk to your doctor about getting a hearing test.
- For questions or more information, contact Texas Early Hearing Detection and Intervention (TEHDI).  
Phone: **1-800-252-8023, ext. 7726** toll free  
(Use relay option of your choice to call if needed.)  
Email: [tehdi@dshs.texas.gov](mailto:tehdi@dshs.texas.gov)  
Website: [www.dshs.texas.gov/tehdi](http://www.dshs.texas.gov/tehdi)

# Lead Risk Questionnaire

**Purpose:** To identify children who need to be tested for lead exposure.

## Instructions

- If **Yes** or **Don't Know**, test the child immediately.
- You may administer a blood lead test instead of using this questionnaire.
- For more information, contact the Texas Childhood Lead Poisoning Prevention Program at: 1-800-588-1248.

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Administered by: \_\_\_\_\_ Date \_\_\_\_\_

## Questions

	Yes or Don't Know	No
1. Does your child live in or visit a home, day-care or other building built before 1978?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your child live in or visit a home, day-care or other building with ongoing repairs or remodeling?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does your child eat or chew on non-food things like paint chips or dirt?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does your child have a family member or friend who has or did have an elevated blood lead level?	<input type="checkbox"/>	<input type="checkbox"/>
5. Is your child a newly arrived refugee or foreign adoptee?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child come in contact with an adult whose job or hobby involves lead exposure?	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>Examples</i></p> <ul style="list-style-type: none"> <li>• House construction or repair</li> <li>• Battery manufacturing or repair</li> <li>• Burning lead-painted wood</li> <li>• Automotive repair shop or junk yard</li> <li>• Going to a firing range or reloading bullets</li> <li>• Chemical preparation</li> <li>• Valve and pipe fittings</li> <li>• Brass/copper foundry</li> <li>• Refinishing furniture</li> <li>• Making fishing weights</li> <li>• Radiator repair</li> <li>• Pottery making</li> <li>• Lead smelting</li> <li>• Welding</li> </ul>		
7. Does your family use products from other countries such as pottery, health remedies, spices, or food?	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>Examples</i></p> <ul style="list-style-type: none"> <li>• Traditional medicines such as Ayurvedic, greta, azarcón, alarcón, alkoohl, bali goli, coral, ghasard, liga, pay-loo-ah, and rueda</li> <li>• Cosmetics such as kohl, surma, and sindor</li> <li>• Imported or glazed pottery, imported candy, and imported nutritional pills other than vitamins.</li> <li>• Foods canned or packaged outside the U.S.</li> </ul>		

**Test Immediately**

## Texas Department of State Health Services Tuberculosis (TB) Questionnaire for Children

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

Organization administering questionnaire \_\_\_\_\_ Date \_\_\_\_\_

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have TB disease (this is called latent TB infection or LTBI).

**Tuberculosis is preventable and treatable.** TB skin testing (often called the PPD or Mantoux test) or a TB blood test (called an IGRA) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The test is not a vaccination against TB.

### We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box	Yes	No	Don't Know
TB can cause a fever of long duration, unexplained weight loss, a cough (lasting over two weeks), or coughing up blood. <b>As far as you know has your child:</b> <ul style="list-style-type: none"> <li>• been around anyone with any of these symptoms or problems? or</li> <li>• had any of these symptoms or problems? or</li> <li>• been around anyone sick with TB?</li> </ul>			
<b>Was your child born in:</b> Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
<b>Has your child traveled in the past year to:</b> Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries:			
<b>To your knowledge, has your child spent time (longer than 3 weeks) with:</b> anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB?  Yes (specify date \_\_\_/\_\_\_/\_\_\_\_)  No  
 Has your child ever had a positive TB skin test?  Yes (specify date \_\_\_/\_\_\_/\_\_\_\_)  No  
 Has your child ever had a positive TB blood test?  Yes (specify date \_\_\_/\_\_\_/\_\_\_\_)  No

**For school/healthcare provider use only**

\*\*\*\*\*

PPD / IGRA administered (circle one)

Date Administered: \_\_\_/\_\_\_/\_\_\_\_ Date Read (if PPD): \_\_\_/\_\_\_/\_\_\_\_

Result of PPD: \_\_\_\_\_ mm Result of IGRA test:  Positive  Negative  Indeterminate/Invalid

Type of service provider (i.e. school, Health Steps, other clinics): \_\_\_\_\_

PPD/IGRA provider: \_\_\_\_\_  
signature printed name

Provider phone number: \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_

If positive, referral to healthcare provider:  Yes  No

If yes, name/contact of provider: \_\_\_\_\_