For each patient, conduct a risk assessment that takes into consideration recent exposure, clinical conditions that increase risk for TB disease if infected, and the program’s capacity to deliver treatment for latent TB infection to determine if the skin test should be administered.

1. **Administration**
   - **Locate and clean injection site**
     - Place forearm palm side up on a firm, well-lit surface.
     - Select an area free of blemishes (e.g., scars, venous) in placing and reading.
     - Clean the area with an alcohol swab.

2. **Prepare syringe**
   - **Check expiration date on vial and ensure vial contains tuberculosis (5 TU per 0.1 ml).**
   - Use a single-dose tuberculosis syringe with a ¼- to ½-inch, 27-gauge needle with a short bevel.
   - Fill the syringe with 0.1 ml of tuberculin.

3. **Inject tuberculin**
   - **Insert slowly, bevel up, at a 5- to 15-degree angle below skin surface.**

4. **Check skin test**
   - **Wheal should be 6 to 10 mm in diameter.** If not, repeat test at a site at least 2 inches away from original site.

5. **Record measurement of induration in mm**
   - If no induration, record as 0 mm.
   - Do not record as “positive” or “negative.”
   - Only record measurement in mm.

**Note:** Reliable administration and reading of the tuberculin skin test involves standardization of procedures, training, supervision, and practice. Always follow your institution’s policies and procedures regarding infection control, evaluation, and referral. Also, remember to provide culturally appropriate patient education before and after administration, reading, and interpretation of the skin test.

For more information on tuberculosis, visit www.cdc.gov/tb