

Positive Tuberculin Skin Test (TST) Reporting Form

Under the Health Protection and Promotion Act, diagnoses of Tuberculosis (TB) infection and/or disease must be reported to Public Health. This includes:

- All patients with clinical, suspected and lab confirmed cases of TB disease (pulmonary and extra-pulmonary)
- All patients with latent TB infection (LTBI), indicated by a positive tuberculin skin test (TST), regardless of plans for prophylaxis. (Refer to the *Canadian Tuberculosis Standards*, 7th edition for guidelines on reading a TST and follow-up of a positive skin test).

If you think your patient may have active TB, please call 613 966 5500 x349 immediately

**PLEASE FAX FORM WITH APPROPRIATE SECTION(S) COMPLETED TO THE
COMMUNICABLE DISEASE TEAM AT 613-966-1813 (CONFIDENTIAL)**

Patient Name: (LAST, First):		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
DOB: (yyyy/mm/dd)	Health Card:	Phone (H):
Address:		Postal Code:
Birth Place: <input type="checkbox"/> Canada <input type="checkbox"/> Other (specify):		Date of entry to Canada:
History of BCG vaccine: <input type="checkbox"/> Y <input type="checkbox"/> N	Age BCG given:	

Section 1 Tuberculin Skin Test Reporting

To be completed in full by person planting and/or reading positive TST

Tuberculin Skin test:	Date: _____	Induration: _____ (mm)	Result:
	Date: _____	Induration: _____ (mm)	<input type="checkbox"/> positive <input type="checkbox"/> negative
			<input type="checkbox"/> indeterminate

Reason for testing: school work volunteer contact medical

Health Care Provider Name	Clinic Office Address/Phone
Signature/Designation	

Has the above patient been referred to another health care provider (HCP) for assessment and chest x-ray? (Section 2 – see reverse)

No – **Continue to Section 2** and complete assessment/follow-up of positive TST information

Yes – HCP Name: _____ Phone: _____
(Please provide patient with copy of this form for completion by HCP)

OR – Would you like Public Health to refer patient to a Respirologist for follow-up of positive TST?

Yes – please inform your patient to expect a phone call from a Public Health Nurse

**PLEASE FAX FORM WITH APPROPRIATE SECTION COMPLETED TO THE
COMMUNICABLE DISEASE TEAM AT 613-966-1813 (CONFIDENTIAL)**

Client Name _____
(LAST, first)

DOB: _____
(yyyy/mm/dd)

**Section 2 Assessment of Patient with Positive Tuberculin Skin Test
and/or positive Interferon Gamma Release Assay (IGRA)**

**To be completed by HCP providing assessment of positive TST
If a TST or IGRA is positive, please order a chest x ray & attach copy of result**

Interferon-Gamma Release Assay (IGRA) if applicable	Date:	Result (please attach copy): <input type="checkbox"/> Positive <input type="checkbox"/> Negative
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Chest x-ray Date:	Result (pls attach copy): <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
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TB-like Symptoms:

<input type="checkbox"/> None	<input type="checkbox"/> cough > 2 weeks	<input type="checkbox"/> fever	<input type="checkbox"/> weight loss
<input type="checkbox"/> Yes - onset date: _____	<input type="checkbox"/> night sweats	<input type="checkbox"/> fatigue	<input type="checkbox"/> loss of appetite
	<input type="checkbox"/> hemoptysis		

If patient is symptomatic and/or active TB is suspected, collect 3 sputum samples (taken at least 1 hour apart) and submit for microscopy and culture. Please fax results when available.

Sputums done? No Yes – Date: _____

Medical Risk Factors: none
HIV/AIDS diabetes renal failure head/neck cancer immunosuppressive therapy/disease

Other Risk Factors:
 Travel (specify) _____ known exposure to active TB
 Aboriginal descent Aboriginal contact Lives or has lived in aboriginal community

Has TB disease (active TB) been ruled out? Yes No

Are you prescribing anti-tuberculosis medication for:
 TB disease No Yes Latent Tuberculosis Infection (LTBI) No Yes

If yes, please provide a complete prescription for your patient and have him/her contact Public Health to receive publicly funded tuberculosis medications. 613-966-5500 x 349

(Refer to the *Canadian Tuberculosis Standards*, 7th edition, for interpretation of positive TST guidelines and treatment recommendations.)

OR - Would you like Public Health to refer this patient to a Respirologist for follow-up?
 No Yes *(If Yes, please inform your patient to expect a phone call from a Public Health Nurse)*

Health Care Provider Name	Clinic Address/Phone:
Signature/Designation	

Personal information on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c.H.7,s.26;R.R.O. 1990, Reg.569, s.1(2), amended and in accordance with PHIPA and will be used for assessment, management, treatment and reporting purposes. Questions about this collection should be addressed to the Privacy Officer at Hastings Prince Edward Public Health Unit, Belleville ON K8P 4P1 613-966-5500 or 1-800-267-2803 | TTY 711 or 1-800-267-6511