PublicHealth
WELLINGTON-DUFFERIN-GUELPH
*Stay Well.*

# Positive TB Skin Test (TST) Reporting Form



Under the *Health Protection and Promotion Act*, diagnoses of tuberculosis (TB) infection and/or disease must be reported to the local Medical Officer of Health. This includes:

- All patients with clinical, suspected or 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

**IF YOU THINK YOUR PATIENT MAY HAVE ACTIVE TB, PLEASE CALL 1-800-265-7293 x 4752 IMMEDIATELY**

**Please fax completed form and chest x-ray report to 1-855-934-5463 (confidential fax line)**

| **CLIENT INFORMATION** | | |
|---|---|---|
| **Name (Last, First):** | **Date of Birth (yyyy/mm/dd):** | **Gender:** □ Male □ Female □ Other |
| **Address/City/Postal Code:** | **Home Phone:** | **Cell Phone:** |
| | **Family Physician and Phone Number:** | |
| **Country of Birth:** □ Canada □ Other: | **Date Arrived in Canada: (yyyy/mm/dd):** | |

**Reason for Testing:** □ Employment □ Volunteer □ School □ Pre-biologics □ Pre-transplant □ Immigration medical surveillance □ Contact of a case □ Symptoms □ Other:

**Previous TST Result:**

□ No □ Yes Date (yyyy/mm/dd): _____ Result:_____ mm induration

**BCG History:**

□ Unknown □ No □ Yes Age Given:_____ Country:_____

**Symptom Assessment:**

□ Asymptomatic

□ **Symptomatic Onset date:** _____
□ Cough □ Weight loss □ Fever □ Night sweats □ Other:

**Risk Factors:**

- □ None identified
- □ Recent TB infection
- □ Contact of an infectious TB case
- □ Canadian-born Indigenous person
- □ Young age (0-4 years)
- □ Underweight (<20 BMI, <90% ideal wt)
- □ Has resided/traveled in countries with high rates of TB ≥ 3 months
- □ Has resided in a Canadian Indigenous community ≥ 3 months
- □ Immunosuppresive therapy/disease
- □ HIV positive
- □ Diabetes
- □ Chronic renal failure, on dialysis
- □ Cancer of the head or neck
- □ Silicosis
- □ Health care/correctional facility employee/volunteer
- □ Long-term care resident
- □ Correctional facility resident
- □ Homeless
- □ Tobacco use (≥1 pack/day)
- □ Heavy alcohol use (>3 drinks/day)
- □ Inhaled/injection illegal drug use
- □ Other:

**TST RESULTS:** (clients with a previous documented positive TST (in mm induration) do not need a repeat TST

| **Step 1 TST** | | | |
|---|---|---|---|
| Date Given (yyyy/mm/dd): | Date Read (yyyy/mm/dd): | Result: mm | HCP Name/Designation: |
| **Step 2 TST** | | | |
| Date Given (yyyy/mm/dd): | Date Read (yyyy/mm/dd): | Result: mm | HCP Name/Designation: |

**NEXT STEPS:**

□ Referred to Family Physician:
Name: _____ Phone: _____

□ No Family Physician, will attend a Walk-in-Clinic
Name: _____

□ *No Family Physician, wishes to be seen at TB Clinic*
□ *Chest x-ray requisition given*



**Additional Physician/HCP Follow-Up on Page 2**

# Positive TB Skin Test (TST) Reporting Form



## Physician/HCP Follow-Up

| **Client Name (Last, First):** | **Date of Birth (yyyy/mm/dd):** |
|---|---|
| | |

**Symptom assessment and physical exam**

| | |
|---|---|
| □ **Asymptomatic** | □ **Symptomatic**** **Onset date:** _____<br>□ Cough □ Fever □ Hemoptysis □ Night sweats □ Fatigue □ Weight loss □ Other |

**Risk Factors for Disease Progression:**

□ None identified
□ As identified on page 1
□ Additional risk factors not identified on page 1:

**Chest X-Ray** (Please fax copy of chest x-ray with this form to Public Health)

| | |
|---|---|
| **Date:** | **Result:** □ **Normal**<br>□ **Abnormal**** |

****** If your client is symptomatic or has an abnormal chest x-ray indicating TB disease, call Wellington Dufferin Guelph Public Health immediately at **1-800-265-7293, ext. 4752**. Advise client about the collection of three sputum specimens (taken at least one hour apart), isolating at home (with masks) and to expect a call from a Public Health Nurse.

**Sputums sent for AFB and Culture?** □ **No**
□ **Yes – Date** (yyyy/mm/dd)**:**

**Interferon-Gamma Release Assay (IGRA)/QuantiFERON®-TB Gold (QFT), if applicable**

□ Counsel client re: cost and locations for testing (see LifeLabs or Gamma-Dynacare websites)
□ Provide lab requisition (MOHLTC requisition may be used)
□ IGRA completed
□ IGRA pending
(Please fax copy of IGRA report with this form to Public Health)

**Active TB Has Been Ruled-Out:**

□ **YES**
□ **NO ****

**Prophylaxis Medications for the treatment of Latent TB Infection (LTBI)**

Medications are provided free of charge from Public Health
□ Prophylaxis discussed
□ Prophylaxis prescribed
  □ Side effects of TB medications discussed
  □ Fax copy of prescription and baseline liver function tests to Public Health
  □ *Provide requisition to client for follow-up LFTs*
□ Prophylaxis not recommended
□ Prophylaxis refused by client

**Client Education /Counselling**

□ Advise client not to repeat TST in the future
□ Signs and symptoms of TB disease
□ When to seek medical attention

| **Referral to a Specialist:** □ **Yes** □ **No** | **Referral to TB Clinic:** □ **YES** □ **NO** |
|---|---|
| Specialist Name:<br><br>Phone: | Please make referral to Dr. V. Shende, WDGPH TB Clinic and fax with a copy of the client's chest x-ray to Public Health at **1-855-934-5463**.<br>Advise client that Public Health will call with an appointment date and time. |
| **Physician/HCP Name** (please print)**:**<br><br>**Physician/HCP Signature:** | **Date (yyyy/mm/dd):**<br><br>**Phone:** |