Tuberculosis Physician Reporting Form

Last Name: **First Name:** **Address:** **Phone Number: (H):** **(C):**	**Date of Birth:** YYYY- MM-DD **Country of birth:** **Province:**	**Gender:** ❑ **MALE** ❑ **FEMALE** **Date of Arrival:** YYYY- MM-DD

Reason for test: ❑ Employment ❑ Pre-biologics ❑ Symptoms ❑ Immigration Medical Surveillance (IMS) ❑ Volunteer Work ❑ Contact of Case ❑School ❑ Other_____

Past TST Result	**Client with a documented positive TST and/or IGRA**	**BCG: Vaccination History**
Date Given: YYYY-MM-DD Date Read: YYYY-MM-DD Result: _____ mm induration	▪ **Requires a symptom assessment, physical exam and CXR** ▪ **Sputum x3 for AFB/culture if client has TB symptoms or an abnormal CXR (see Physician Medical Assessment below)**	❑ NO ❑ YES ❑ Unknown Age(s) received:

TST Results		**IGRA (i.e. QFT)**	**Chest X-Ray (CXR)**
Step 1- if positive do not repeat	**Step 2**	Ordered: Yes ☐ No ☐ Report to be faxed to the HRHD	Required with a positive TST and/or IGRA
Date Given: YYYY-MM-DD Date Read: YYYY-MM-DD Result: _____ mm induration	Date Given: YYYY-MM-DD Date Read: YYYY-MM-DD Result: _____ mm induration	**HIV Testing is recommended for all positive TSTs/IGRAs** Ordered: Yes ☐ No ☐ Report to be faxed to the HRHD	Report **must be faxed** to the HRHD along with this form

Physician Medical Assessment

❑ **Asymptomatic** **Symptomatic** ❑ **Cough** ❑ **Fever** ❑ **Night Sweats** ❑ **Fatigue** ❑ **Other:** _____

*** If your client is symptomatic or has an abnormal chest x-ray indicating TB disease, call the Halton Region Health Department (HRHD) immediately at 905.825.6000 x7341 and instruct client to isolate at home.

Behavioural/Social Risk Factors ❑ None identified		**Medical Risk Factors** ❑ None identified	
❑ Injection drug user	❑ Mental Health Condition	❑Organ transplant	❑Renal Disease
❑ Close contact of a case	❑ Lived in endemic country	❑Past treatment for TB	❑Diabetes
❑ Alcohol abuse	❑ Prolonged travel to a TB endemic country	❑HIV/AIDS	❑Immunosuppressed - Biologics
❑Smoker	❑ Other:_____	❑Cancer	❑Immunosuppressed - Disease
❑Homeless/Under housed		❑Silicosis	❑ Other: _____

Counselling/Intervention (check all that apply)

❑ Signs and symptoms of TB discussed
❑ When to seek medical attention discussed
❑ Reviewed TB fact sheet (available on Halton website)
❑ Prophylaxis discussed
❑ Prophylaxis not recommended
❑ Prophylaxis refused by client
❑ Prophylaxis prescribed – refer to LTBI treatment section
❑ Client referred to ID Specialist /Respirologist
Dr._____ Apt. date: _____

LTBI Treatment Section **Order through Pharmex Direct Inc. Tel: 905.847.8224 or Fax: 905.847.8271**

Medication (Weight based)	**Prescription** (Standard regime)	**Prescription** (leave blank if ordering standard)	**Duration** (in months)
Isoniazid (INH)	☐ Standard: 300 mg Oral Daily	_____ mg Oral _____	6 **9** 12
Pyridoxine (B6)	☐ Standard: 25 mg Oral Daily	_____ mg Oral _____	6 **9** 12
Rifampin (RIF)	☐ Standard: 600 mg Oral Daily	_____ mg Oral _____	**4** 6

Physician name (print):_____
Signature: _____ Date: _____
Address:
Tel: Fax:

Legend

TST – tuberculin skin test
HRHD – the Halton Region Health Department
LTBI – Latent tuberculosis infection

Please FAX COMPLETED form to: The Halton Region Health Department at 905-825-8797 **January 2019**