Huron Perth Public Health

Report: **Positive Tuberculin Skin Test (TST) and/or Interferon Gamma Release Assay (IGRA)**

Client information

Fax completed form to confidential line 519-271-2195.

1

First name _____ Last name _____

Date of birth *(yyyy/mm/dd)* _____ Age _____ Gender: ○ F ○ M ○ Other

Address *(911)* _____

City or town _____ Province _____ Postal code _____

Phone _____ Email _____

Country of birth _____ Language spoken _____

Interpreter required: ○ No ○ Yes Proxy name _____

Reason for testing

2

☐ Contact/exposure to TB Relationship _____

☐ Immigration screen

☐ Occupation/school/volunteer/daycare Occupation/study area _____

☐ Medical reasons Specify _____

☐ Travel Country _____ Date *(yyyy/mm/dd)* _____

☐ Signs and symptoms of active TB

Other _____

Client history

3

Previous TST: ○ Yes ○ No If yes, date given *(yyyy/mm/dd)* _____

Date read *(yyyy/mm/dd)* _____ Result *(mm)* _____

TST and IGRA information

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Skin Test #1

Date given *(yyyy/mm/dd)* _____

Date read *(yyyy/mm/dd)* _____

Result *(mm)* _____ ○ Positive ○ Negative

Skin Test #2

Date given *(yyyy/mm/dd)* _____

Date read *(yyyy/mm/dd)* _____

Result *(mm)* _____ ○ Positive ○ Negative

IGRA

Date given *(yyyy/mm/dd)* _____

Result: ○ Positive ○ Negative

Report positive results if:

greater than or equal to 5mm induration & one of the following indicators are met

HIV+, known contact to active TB, Fibronodular disease, prior to organ transplant and immunosuppressive therapy, receipt of biologic drugs, stage 4 or 5 kidney disease

greater than or equal to 10mm induration & one of the following indicators are met

<2 years TST from -ve to +ve, diabetes, malnutrition, tobacco smoker, daily consumption >3 alcoholic drinks, silicosis, hematologic malignancies and certain carcinomas, any population considered low risk of disease

Adapted from Canadian Tuberculosis Standards (8th ed.) ch. 4, table 1. Interpretation of TST result and cut off thresholds in various populations.

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Symptom review

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Symptoms:

- ☐ Persistant cough for three weeks or more
- ☐ Sputum production
- ☐ Hemoptysis
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Fever
- ☐ Night sweats
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Fatigue
- ☐ Asymptomatic

Other _____

Reported by

Required

6

Name _____ Agency/facility _____

Phone _____ Fax _____

Sign and date here *(Required)*

X _____

Date *(yyyy/mm/dd)* _____

Personal health information

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Personal information is collected under the authority of the *Health Protection and Promotion Act (part VII)* and in accordance with the *Personal Health Information Protection Act* and/or the *Freedom of Information and Protection of Privacy Act*, for the purposes of providing public health programs and for statistical purposes. For more information see www.hpph.ca/privacy.