Huron Perth Public Health

Healthcare Provider Follow-Up Report: **Positive Tuberculin Skin Test (TST) and/or Interferon Gamma Release Assay (IGRA)**

Client information

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 _____

Client history

*Bacille Calmette-Guérin

2

Arrival date in Canada *(yyyy/mm/dd)* _____

Recent travel for >1 month: ○ Yes ○ No If yes, country _____

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

Previous exposure to tuberculosis (TB): ○ Yes ○ No ○ Unknown

If yes, specify _____

☐ Previously treated for active TB (list medications, date and duration of treatment):

☐ Provided prophylaxis for latent TB infection (LTBI) (list medications, date and duration of treatment):

Symptom review

Fax completed form with chest x-ray/ sputum results to confidential line 519-271-2195.

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Symptoms:

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

Other _____

Chest x-ray:
Date *(yyyy/mm/dd)* _____
Result: ○ Normal ○ Abnormal

Sputum:
Date *(yyyy/mm/dd)* _____ Result _____
Date *(yyyy/mm/dd)* _____ Result _____
Date *(yyyy/mm/dd)* _____ Result _____

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Planned intervention

Indicate your planned intervention by checking the appropriate box.

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If evidence of active TB:

☐ Consult with respirologist and instruct client to isolate. Notify HPPH.

If no evidence of active TB:

☐ Please discuss LTBI treatment and then select one of the following:

- ☐ Refer to Respirologist or Infectious Disease Specialist for LTBI treatment.
  Name _____
- ☐ LTBI treatment refused.

☐ Advise client of signs and symptoms of active TB and to seek medical attention immediately. Follow up with client as indicated.

☐ Other (please explain):

Healthcare Provider

Required

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Name _____ Phone _____

Email _____ Fax _____

Healthcare Provider, 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.