



**TUBERCULOSIS CONTROL PROGRAM
LTBI REPORTING FORM
POSITIVE REPORT: TB SKIN TEST OR IGRA SEROLOGY**

PATIENT INFORMATION:

Name: _____ DOB: ____/____/____ Gender: M ___ F ___
YY MM DD

OHCN: _____ Phone: _____

Address: _____ Postal Code: _____

Country of Birth: _____ Date of Arrival in Canada if known: _____

POSITIVE RESULT INFORMATION:

Date of Current TB Skin Test. Date Planted: ____/____/____ Date Read: ____/____/____ Induration: ____mm
YY MM DD YY MM DD

If known,

Date of Previous TB Skin Test. Date Planted: ____/____/____ Date Read: ____/____/____ Induration: ____mm
YY MM DD YY MM DD

Was IGRA drawn? Yes No - if yes, date IGRA Serology Drawn: ____/____/____
YY MM DD

***Fax copy of IGRA result if completed to TBDHU.**

Does client have BCG vaccine? Yes No Unknown - if yes, date received: ____/____/____
YY MM DD

Reason for Current Test:

Pre-employment: Screening: Diagnosis: Contact of TB: if yes, when: ____ Other: _____

FOLLOW UP:

Symptoms? (i.e. cough, weight loss, fatigue, fever, night sweats or hemoptysis): Yes No

***If yes, notify TBDHU Infectious Disease Program by calling (807)625-8318 promptly.**

Chest X-ray: Date: ____/____/____ Results: _____
YY MM DD

***Fax a copy of chest x-ray report to TBDHU.**

If indicated, please complete 3 sputa samples. Were sputa taken: Yes No

Referred for Medical Consult: Yes No - if yes, indicate specialist: _____

Was Treatment Initiated? Yes - Planned Length of Treatment: 4 6 9 12 Months

No - Reason: LTBI Diagnosis, treatment declined, counselled on signs/symptoms of active disease

LTBI diagnosis, treatment not recommended, counselled on signs/symptoms of active disease

***Fax prescription to TBDHU at (807)625-4822.** TB medication is provided by TBDHU at no cost to patient upon receipt of prescription.

REPORTING HEALTH CARE PROVIDER INFORMATION:

Name: _____ Address: _____
 Phone number: _____ Date: _____

***Please fax this report (along with other information as indicated) to the Infectious Disease Program, TBDHU at (807)625-4822.**

Personal information collected on this form is under the authority of the Health Protection and Promotion Act, R.S.O. 1990, as amended and in accordance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 and the Personal Health Information Protection Act, 2004. The information collected is to maintain an immunization record for this client. Direct any questions regarding the collection of this information to the Privacy Officer, Thunder Bay District Health Unit, 999 Balmoral Street, Thunder Bay, ON P7B 6E7 Telephone (807) 625-5900.