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.