Positive TB Skin Test Notification

Fax completed form to Southwestern Public Health

Elgin-St. Thomas: 519-631-1682 **Oxford: 519-539-6206**

First Name		**Last Name**			
Date of Birth		**Gender**	☐ Male ☐ Female ☐ Other:		
Address		**Phone Number**			
		Country of Birth		**Date of Arrival**	

Reason for TB Testing

☐ Work	☐ Volunteer Work	☐ Symptoms	☐ Contact of a case	☐ Other:
☐ School	☐ Immigration Medical Surveillance (IMS)		☐ Pre-biologics	

Test Results

TB Skin Test(s) (optional for IMS, not needed if previous documented positive TST)		**Chest X-Ray**	**QuantiFERON®**
Date Given: YYYY/MM/DD	**Date Given:** YYYY/MM/DD	Required for clients with positive TST or positive QFT **Date:** YYYY/MM/DD	☐ Complete **Date:** YYYY/MM/DD
Date Read: YYYY/MM/DD	**Date Read:** YYYY/MM/DD		☐ Pending **Date:** YYYY/MM/DD
Result (mm):	**Result (mm):**	CXR report **must be** faxed along with this form	Fax a copy of report along with this form

Clients with a documented positive TB skin test require:

- A symptom assessment and a physical exam
- A chest x-ray
- Additional tests (sputum for AFB and culture) as necessary

History of BCG Vaccination

☐ Yes	**Date:**	**Country:**	☐ No	☐ Unknown

Health Care Provider Medical Assessment

☐ Asymptomatic	☐ Symptomatic	Symptoms:	Onset Date(s)

***** If your client is symptomatic or has an abnormal chest x-ray indicating TB disease instruct client to isolate at home and call Southwestern Public Health immediately at 1-800-922-0096*****

Risk Factors for Developing Active Disease

High Risk	☐ HIV/AIDS ☐ Transplantation (related to immune suppressant therapy) ☐ Silicosis ☐ Chronic Renal Failure (requiring dialysis) ☐ Recent TB Infection (< 2 years) ☐ Abnormal CXR, fibronodular disease (healed TB not previously treated)
Moderate Risk	☐ Treatment with TNF inhibitors ☐ Treatment with glucocorticoids equivalent to prednisone (>15 mg/day) ☐ Diabetes mellitus ☐ Young age when infected (0-4 years) ☐ Heavy alcohol consumption (>3 drinks/day) ☐ Underweight (<90% ideal body weight, generally BMI <20) ☐ Cigarette smoking (1 pack/day) ☐ Abnormal CXR (granuloma)
Low Risk	☐ Person with positive TST, no known risk factors, normal CXR

Client Education/Recommendations for Follow-Up

☐ Discussed signs and symptoms of TB and when to seek medical attention

☐ Discussed prophylaxis

☐ Prophylaxis not recommended. Reason:

- ☐ Client refused
- ☐ Reliable documentation of previous treatment and adherence has been obtained
- ☐ Other: _____

☐ Prophylaxis prescribed - refer to LTBI treatment section*

☐ Referred client to an Infectious Disease Specialist /Respirologist: _____

☐ Other: _____

LTBI Treatment* (TB medications are free of charge. Fax prescription to your local public health unit)

Medication	Dose/Route/Frequency	Duration	Comments
☐ INH	_____ mg po daily	_____ months	
☐ Vitamin B6	_____ mg po daily	_____ months	
☐ Rifampin	_____ mg po daily	_____ months	
_____	_____	_____ months	

Physician Signature _____ **Date** _____