POSITIVE TB SKIN TEST (TST) / IGRA REPORTING FORM

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

Please complete and fax this form and chest x-ray to 855-934-5463 within 7 days

Patient's Last name, First name, Middle name:	**Date of birth:**	**Gender**
	(dd/mm/yyyy)	☐ Female ☐ Male ☐ Transgender ☐ Other
Address, City, Postal Code	**Phone Number**	**Family Physician**
Born in Canada ☐ Yes – Province ☐ No Yes – identify as: First Nation ☐ Metis ☐ Inuit ☐ Other Indigenous:	**Country of Birth**	**Date of Arrival** (dd/mm/yyyy)

Reason for Test: ☐ Routine screening (includes volunteer, school, work) ☐ Immigration
Symptomatic – Specify ☐ Other – Specify

History of TST: ☐ Unknown ☐ No ☐ Yes Result: Date:

First TST	**Second TST**	**IGRA**	**BCG Vaccine Hx**
Date Planted: Date Read: Result: mm induration	Date Planted: Date Read: Result: mm induration	Positive ☐ Negative ☐ N/A ☐ **Please fax IGRA results along with this form**	Unknown ☐ No ☐ Yes ☐ Year:

Positive TST: 10mm or more is considered positive for most people
5mm or more may be considered positive in specific situations listed in the Canadian TB Standards 8th Ed., Chapter 4, Table 1

Note: A person with documented positive TST in mm induration does not require further TST's. Proceed to chest x-ray and follow-up.

Patients with positive TST require: Symptom assessment, chest x-ray and physical exam to rule out active TB
Chest x-ray – Date: Send form and chest x-ray to: 1-855-934-5463

Symptom Assessment

☐ **Asymptomatic** ☐ **Symptomatic** – specify ☐ cough ☐ fever ☐ night sweats ☐ fatigue ☐ other:

Active TB ruled out: ☐ Yes ☐ No (call for further instructions) Phone 1-519-829-8370

Risk Factors for TB Disease Progression

Check all that apply:
- ☐ No risk factors
- ☐ HIV infection
- ☐ Close contact of an infectious TB case (within 3 years)
- ☐ Age when infected – under 5 years
- ☐ Silicosis
- ☐ Chronic renal failure/hemodialysis
- ☐ Transplant recipient
- ☐ Fibronodular disease
- ☐ Receiving immunosuppressive drugs
- ☐ Cancer (lung, sarcoma, leukemia, lymphoma or gastrointestinal)
- ☐ Granuloma on chest x-ray
- ☐ Diabetes
- ☐ Alcohol use (3 or more drinks/day)
- ☐ Tobacco cigarette use (1 or more packs/day)
- ☐ Underweight (less than 90% ideal body weight)
- ☐ Has resided/traveled in countries with high rates of TB ≥3 months

Health Education and Follow-Up

- ☐ Reviewed signs & symptoms of active TB and when to seek health care
- ☐ LTBI Therapy Discussed
  - ☐ I would like to refer this patient to WDGPH's TB clinic for LTBI therapy
  - ☐ I have referred this patient to another provider for LTBI therapy (Name:)
  - ☐ I will be prescribing LTBI therapy for this patient
  - ☐ LTBI therapy declined (no further follow-up needed)

Health Care Provider Name: **Date**:

Address **Phone** **Fax**