

# POSITIVE TB SKIN TEST (TST) / IGRA REPORTING FORM



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

<b>Patient's last name, First name, Middle name:</b>		<b>Date of birth:</b>	<b>Gender</b>	
		(dd/mm/yyyy)	Female	Male
			Transgender	Other
<b>Address, City, Postal Code</b>		<b>Phone Number</b>	<b>Family Physician</b>	
<b>Born in Canada</b> Yes – Province    No Yes – identify as: First Nation    Metis    Inuit Other Indigenous:		<b>Country of Birth</b>	<b>Date of Arrival</b>	
			(dd/mm/yyyy)	
<b>Reason for Test:</b> Routine screening (includes volunteer, school, work)    Immigration Symptomatic – Specify    Other – Specify				
<b>History of TST:</b> Unknown    No    Yes    Result:    Date:				
<b>First TST</b>		<b>Second TST</b>		<b>IGRA</b>
Date Planted: Date Read: Result:    mm induration		Date Planted: Date Read: Result:    mm induration		Positive Negative N/A <b>Please fax IGRA results along with this form</b>
<b>BCG Vaccine Hx</b> Unknown No Yes Year:				
<b>Positive TST:</b> 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 8 <sup>th</sup> Ed., Chapter 4, Table 1 <b>Note:</b> A person with documented positive TST in mm induration does not require further TST's. Proceed to chest x-ray and follow-up.				
<b>Patients with positive TST require:</b> Symptom assessment and physical exam to rule out active TB <b>Chest x-ray – Date:</b> Send form and chest x-ray to: 1-855-934-5463				
<b>Symptom Assessment</b>				
<b>Asymptomatic</b>	<b>Symptomatic – specify</b> cough    fever    night sweats    fatigue    other:			
<b>Active TB ruled out:</b> Yes    No (call for further instructions) Phone 1-519-829-8370				
<b>Risk Factors for TB Disease Progression</b>				
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		
<b>Health Teaching</b>				
Reviewed signs & symptoms of active TB and when to seek health care				
<b>Plan of care (please select one of the following):</b>				
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)				
<b>Health Care Provider Name:</b>			<b>Date:</b>	
<b>Address</b>		<b>Phone</b>	<b>Fax</b>	