Huron Perth Public Health

Healthcare Provider Follow-Up Report: **Positive Tuberculin Skin Test (TST) and/or Interferon Gamma Release Assay (IGRA)**

Client information

1

First name ______________ Last name ______________

Date of birth *(yyyy/mm/dd)* ______________ Phone ______________

Client history

*Bacille Calmette-Guérin

2

Country of birth ______________ Arrival date in Canada *(yyyy/mm/dd)* ______________

Recent travel for >1 month: Yes No If yes, country ______________

Previous BCG* vaccine: Yes No If yes, date *(yyyy/mm/dd)* ______________

Previous exposure to tuberculosis (TB): Yes No Unknown

If yes, specify ______________

Previously treated for active TB (list medications, date and duration of treatment):

Provided prophylaxis for latent TB infection (LTBI) (list medications, date and duration of treatment):

Symptom review

Fax completed form with chest x-ray/ sputum results to confidential line 519-271-2195.

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Symptoms:

- None
- Weight loss
- Hemoptysis
- New or worsening cough
- Chest pain
- Loss of appetite
- Night sweats
- Fever/chills
- Fatigue

Other ______________

Chest x-ray:

Date *(yyyy/mm/dd)* ______________

Result: Normal Abnormal

Sputum:

Date *(yyyy/mm/dd)* ______________ Result ______________

Date *(yyyy/mm/dd)* ______________ Result ______________

Date *(yyyy/mm/dd)* ______________ Result ______________

Planned intervention

Indicate your planned intervention by checking the appropriate box.

4

If evidence of active TB:

Consult with respirologist and instruct client to isolate. Notify HPPH.

If no evidence of active TB:

Refer to respirologist or infectious disease specialist for LTBI treatment.

Name ______________

LTBI treatment refused.

LTBI treatment not indicated.

Advise client of signs and symptoms of active TB and to seek medical attention immediately. Follow up with client as indicated.

Other follow-up (please explain):

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Healthcare Provider

Required

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Name ______________________ Phone ______________________

Email ______________________ Fax ______________________

Healthcare Provider, sign and date here *(Required)*

X

Date *(yyyy/mm/dd)* ____________

Personal health information

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Personal information is collected under the authority of the *Health Protection and Promotion Act (part VII)* and in accordance with the *Personal Health Information Protection Act* and/or the *Freedom of Information and Protection of Privacy Act*, for the purposes of providing public health programs and for statistical purposes. For more information see www.hpph.ca/privacy.