Huron Perth Public Health

Healthcare Provider Report:
Tuberculosis (TB) Immigration Medical Surveillance

Client information

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

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First name _____ Last name _____

Date of birth *(yyyy/mm/dd)* _____ Age _____ Gender: ○ F ○ M ○ Other

Address *(911)* _____

City or town _____ Province _____ Postal code _____

Phone _____ Email _____

Country of birth _____ Language spoken _____

Interpreter required: ○ No ○ Yes Proxy name _____

Symptom review

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Symptoms:

☐ None ☐ Night sweats ☐ Fever

☐ New or worsening cough (>3 weeks duration) ☐ Weight loss ☐ Hemoptysis

Other _____

Client history

*Bacille Calmette-Guérin

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Previous exposure to tuberculosis (TB): ○ No ○ Yes ○ Pulmonary ○ Extra pulmonary

Country _____ Year treated _____ Treatment length _____

Medications _____

Chest x-ray posteroanterior and lateral views (done in last 3 months in Canada).
If pregnant and asymptomatic, delay x-ray until postpartum at HCP discretion.

Date *(yyyy/mm/dd)* _____ Result: ○ Normal ○ Abnormal

Previous TB skin test (TST) | If previous positive TST do not perform further TST.

Date tested *(yyyy/mm/dd)* _____ Date read *(yyyy/mm/dd)* _____

Result *(mm)* _____ Interpretation: ○ Positive ○ Negative

Previous BCG*: ○ Yes ○ No ○ Unknown If yes, date *(yyyy/mm/dd)* _____

Assessment outcome

If active TB is suspected, notify Huron Perth Public Health at 1-888-221-2133 ext 3284 or fax to confidential line 519-271-2195.

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Active TB ruled out:

☐ Advise client of signs and symptoms of active TB and to seek medical attention immediately.

☐ Consider follow up visits every 6-12 months for 2 years to monitor for signs and symptoms of active TB. New immigrants are at a higher risk for TB during the first 12-24 months of moving to a new country.

Active TB suspected:

☐ Refer to respirologist* and instruct client to isolate. Notify HPPH.

Follow up for LTBI assessment/treatment indicated:

☐ Refer to respirologist* or infectious disease specialist*. Notify HPPH.

Name* _____

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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.