

Report of a Positive Tuberculin Skin Test Fax to: 905-885-9554

Client last name:		Client first name:	
Birthdate (yyyy/mm/dd):	/ /	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	OHCN:
Address:			
City:		Postal Code:	
Home phone:	Work phone:	Employer Name:	
Occupation:	Ethnicity:	Country of Birth:	

TO BE COMPLETED BY STAFF ADMINISTERING/READING TB SKIN TEST:

1. Reason for tuberculin skin testing:
- contact tracing
 routine screening
 targeted screening
 immigration screening
 immigration self-referral
 unknown
 other :
2. asymptomatic symptomatic (check any/all symptoms reported or observed and indicate onset date Y/M/D) →
- Anorexia ___/___/___
 Cough ___/___/___
 Chest pain ___/___/___
 Fatigue ___/___/___
 Fever/chills ___/___/___
 Night sweats ___/___/___
 Hemoptysis ___/___/___
 Weight loss ___/___/___
 Other ___/___/___

Tuberculin skin test date (y/m/d)	Lot #	Date test read (y/m/d)	Induration	Comments
			mm	
			mm	

4. Has client ever had TB? Unknown No Yes →What year? _____ Country _____
5. Has client ever had chemoprophylaxis? Unknown No Yes
6. Has client had contact with a TB case? Unknown No Yes →contact date: (yyyy/mm) ___/___
7. Previous positive tuberculin? Unknown No Yes → When: (yy/mm) ___/___ Where: _____
8. Has client been vaccinated with BCG? Unknown No Yes →When: (yyyy/mm/dd) ___/___/___
9. Has the client travelled outside of Canada within the last year? Unknown No Yes → complete details:
 Country: _____ Dates of travel: _____
10. Have you provided counselling about latent TB infection and active TB disease? No Yes
 Print Name of person completing form _____ Organization/Phone #: _____
- Signature of person completing form: _____ Date (yyyy/mm/dd) ___/___/___

TO BE COMPLETED BY PHYSICIAN/NURSE PRACTITIONER(NP):

11. Has a chest x-ray been ordered? Unknown No Yes →When: (yyyy/mm/dd) ___/___/___
- Results→ active tuberculosis inactive tuberculosis no tuberculosis pending
12. Was chemoprophylaxis prescribed? No Yes → Attach Prescription → Was liver function tests ordered? No Yes
 Print Name Physician/NP: _____ Organization/Phone #: _____
- Signature of Physician/NP: _____ Date (yyyy/mm/dd): ___/___/___