Lakelands Public Health

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Report of a Positive Tuberculin Skin Test

Client last name:	Client first name:	
Birthdate (yyyy/mm/dd): / /	Gender: ☐ M ☐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):_____/___/___