simcoe muskoka
DISTRICT HEALTH UNIT

Tuberculosis Reporting Form

Patient Demographics

Name: | Date of Birth: yyyy / mm / dd | Sex: ☐ M ☐ F ☐ X

Address: | HCN:

Telephone number: Home ( ) Work: ( ) Cell: ( )

Partner: Next of Kin:

Household members (including ages):

Country of birth:

↳ If not Canadian born Date of arrival: yyyy / mm / dd Country Lived in: Dates: yyyy / mm / dd

If Client is ≤ 15 years of age, parents birth Country is required:

TB History

Previous documented TST: ☐ Yes ☐ No

↳Date of TST: yyyy / mm / dd Induration (mm):

Previous BCG: ☐ Yes ☐ No

↳Date of BCG: yyyy / mm / dd

Previous Active TB: ☐ Yes ☐ No

Treatment: ☐ Yes ☐ No

↳Details: (e.g. drugs, dates)

Previous Latent TB: ☐ Yes ☐ No

Treatment: ☐ Yes ☐ No

↳Details: (e.g. drugs, dates)

Medical History

Allergies:

Have you had a vaccine in the past 6 weeks?

↳ ☐ Yes ☐ No Typ

Do you have any of the following medical conditions?

Diabetes: ☐ Yes ☐ No HIV: ☐ Yes ☐ No ☐ Unknown

Cancer: ☐ Yes ☐ No Chronic renal failure: ☐ Yes ☐ No

Taking immunosuppressant drugs: ☐ Yes ☐ No

Current medication:

Physician Information:

1. Primary Health Care Provider (HCP):

Address:

City: Postal Code:

Telephone: ( ) Fax: ( )

1. Consulting/Treating HCP:

Address:

City: Postal Code:

Telephone: ( ) Fax: ( )

Method of Detection:

Name of Person Reporting: Telephone number:

Reporting Hospital/Facility: Telephone number:

☐ symptoms ☐ screening - Reason for screening (school/ employment/volunteer/immigration)

☐ contact tracing ☐ post mortem ☐ other

Symptoms:

- ☐ asymptomatic
- ☐ cough > 3 weeks
- ☐ fatigue
- ☐ fever
- ☐ hemoptysis
- ☐ night sweats
- ☐ weight loss
- ☐ other: _____

Details of Symptoms: _____

Please note: If there is a suspicion of Active Tuberculosis Disease, please call Simcoe Muskoka District Health Unit at 705-721-7520, ext. 8809 or 1-877-721-7520 ext. 8809 to report.

Risk Factors:

☐ correctional facility ☐ homeless shelter ☐ employment history (Volunteer Work)

☐ LTCF/hospital ☐ recent travel ☐ smoking history ☐ Yes ☐ No How Long? _____

☐ First Nations ☐ known exposure/contact ☐ other _____

Diagnostics:

TST # 1 yyyy / mm / dd Given by: _____

Date read: yyyy / mm / dd Result (mm): _____

TST #2 yyyy / mm / dd Given by: _____

Date read yyyy / mm / dd Result (mm): _____

Chest x-ray ☐ Yes ☐ No Date: yyyy / mm / dd

CT scan ☐ Yes ☐ No Date: yyyy / mm / dd

AFB Specimen # _____ Collected: yyyy / mm / dd

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AFB Specimen # _____ Collected: yyyy / mm / dd

Please include laboratory and radiology reports if available, and indicate below those attached:

Chest x-ray report ☐ Yes ☐ No

CT scan report ☐ Yes ☐ No

AFB #1 ☐ Yes ☐ No

AFB #2 ☐ Yes ☐ No

AFB #3 ☐ Yes ☐ No

Other (specify) _____

Notes: _____

Tuberculosis Health Teaching provided to patient (i.e. latent vs. active TB; S & S; LTBI treatment risks and benefits): ☐ Yes ☐ No

Print Name of Submitter: _____

Signature of Submitter: _____ Date: _____

Please fax form to Simcoe Muskoka District Health Unit, Communicable Disease Department, at 705-733-7738 – Attention: TB Control Program.