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):______/____/______