CK Public Health — Positive TB Skin Test (TST) Reporting Form

Reporting to the local Medical Officer of Health of al positive TB skin tests within 7 days is required under HPPA, Section 25 and 26.

Last Name:_____ First Name: _____

Birth Date: _____ Health Card #: _____
YEAR/MONTH/DAY

Street Address:_____ Gender: ☐ Male ☐ Female ☐ Other

City: _____ Postal Code: _____

Telephone: _____ Health Care Provider: _____

Country of Birth: _____ Date of Entry to Canada: _____

BCG History: ☐ Yes Date:_____☐ No ☐ Unknown

Testing Results

Reason for test: _____ School/Employer Name: _____

TST Step 1	TST Step 2	IGRA	Chest x-ray
Date Given:_____ Date Read:_____ Result:____mm induration	Date Given:_____ Date Read:_____ Result:____mm induration	Date:_____ ☐ Positive ☐ Negative This is not a mandatory test and not covered under OHIP. ***If done, fax IGRA results with this form**	Required for positive TST or IGRA Date:_____ ***Report must be faxed with this form**

All clients with a positive TB skin test must be assessed for signs and symptoms of active tuberculosis:
☐ Asymptomatic ☐ Symptomatic (cough >3 weeks, fever, weight loss, fatigue, night sweats)

IMPORTANT: If your client is symptomatic or has an abnormal chest x-ray indicating TB disease, instruct your client to isolate at home, collect 3 sputum samples at least 1 hour apart, report immediately to CKPH at 519.355.1071 ext. 5902.

Education/Intervention

☐ Signs and symptoms of TB discussed

☐ When to seek medical attention discussed

☐ Treatment for Latent TB Infection (diagnosed when client has positive TST, negative chest x-ray and is asymptomatic) discussed

Latent TB Infection Treatment Plan

☐ Treatment declined by client and health teaching done

☐ Referred to specialist:_____

☐ Treatment not recommended by health care provider (reason): _____

☐ Treatment recommended. TB medications are provided **free** by CKPH. Fax prescription with this form.

Please call 519.355.1071 ext. 5902 for more information.

Health Care Provider:_____ Phone Number: _____

Signature:_____ Date:_____

Please fax completed form to 519.355.0848, Tuberculosis Control Program, CK Public Health