Tuberculosis Control Program - Referral for Medical Follow-up

Date sent: _____

Reason for referral: ☐Contact ☐Positive TB Test ☐ Positive IGRA Test

Please return by fax to York Region Tuberculosis Control Program: Fax: 1-844-209-4389/905-895-5450

Patient surname:_____ Given name:_____ Sex: ☐Male ☐Female

Street address:_____ City:_____ Postal code:_____

Birth date - Y:_____ M:_____ D:____ Phone #:_____ Health card #:_____

Country of birth:_____Index case information: _____

Physician to complete all of the following:

History

1. Any previous TST/IGRA results
   Result:_____mm Date:_____
   Result:_____IU/mL Date:_____
2. Does the client have risk factors to develop TB disease?
   ☐Transplantation
   ☐Silicosis
   ☐Renal/Liver Disease
   ☐Carcinoma of head and neck
   ☐Recent TB infection (≤ 2 years)
   ☐Underweight (less than 90% ideal body weight)
   ☐On treatment with glucocorticoids
   ☐Previous TB exposure
   ☐Diabetes
   ☐Tumor Necrosis Factor
   ☐HIV/AIDS
   ☐Other:_____
3. Has the client received BCG in the past?
   ☐Yes ☐No ☐Unknown
   Date:_____
4. Has the client lived/travelled for longer than 3 months to a TB endemic country?
   ☐Yes ☐No
   Country:_____
   Date:_____
5. Has the client ever worked, volunteered or lived in:
   ☐Shelter ☐Nursing home ☐Correctional facility
   ☐Psychiatric institution ☐Refugee camp

TB Skin Test/IGRA result

☐TST (Date Planted):_____
Date Read:_____Result: _____mm
☐IGRA (QFT):_____
Date:_____Result:_____IU/mL

If the TST or IGRA was or is currently positive, a chest X-ray is required.

Chest X-Ray

If done, provide copy of radiology report (Chest x-ray within last 6 months)

Date of Chest X-Ray - Y:_____M:_____D:_____

Result: ☐Normal ☐Not done ☐Unknown
Abnormal-☐Cavitary ☐Non-Cavitary ☐Not specified

Sputum examination is required if client is symptomatic or has an abnormal chest x-ray.

Was sputum collected? ☐Yes ☐No
Results:_____ Date:_____
Symptoms:_____

Was a referral made for further investigation? ☐Yes ☐No
Name:_____
Telephone:_____

LTBI TREATMENT

Active TB must be ruled out before starting LTBI treatment.

Active TB ruled out? ☐Yes ☐No
Was LTBI treatment Initiated? ☐Yes ☐No
Prescription provided to client: ☐Yes ☐No
Prescription faxed to 1 of 3 pharmacies listed below:
☐Yes ☐No

☐Isoniazid_____mg ☐ Rifapentine (3HP)_____mg
☐Rifampin_____mg ☐Pyridoxine (B6)_____mg
☐Other_____mg

Proposed length of treatment:
☐3 months ☐4 months ☐6 months ☐9 months
☐other_____

York Region has 3 pharmacies that dispense free TB medication. Please ONLY send your patients to one of these:

Pure Health Pharmacy (Mackenzie Health Richmond Hill)	(905) 883-7500 Fax: 905-883-7502
Dales Pharmacy (Markham-Stouffville Hospital)	(905) 471-1234 Fax: 905-471-3732
Care RX Pharmacy (Southlake Regional Health Centre)	(905) 830-5988 Fax: 905-830-5994

Physician's name/stamp:_____ **Date:**_____ **Physician's signature:**_____

TB Office Use Only
☐iPHIS_____ Contact Investigator_____

This information is being collected under the authority of the *Health Protection and Promotion Act,* R.S.O. 1990, c.H.7 for the purpose of obtaining and maintaining a medical history to provide or assist in the provision of treatment for tuberculosis, case management, client follow up, monitoring and contact tracing, public health administration and for the provision of data to the Ministry of Health and Public Health Ontario. This information will be retained, used, disclosed and disposed of in accordance with the *Personal Health Information Protection Act, 2004*. Any questions regarding this collection may be directed to the Manager of Tuberculosis Control, 9060 Jane Street, 5th Floor, Vaughan ON L4K 0G5, (905) 830-4444 extension 73065