EOHU Eastern Ontario Health Unit | BSEO Bureau de santé de l'est de l'Ontario

Tuberculosis Reporting Form

Patient Demographics

Name: _____

DOB: _____ HCN: _____ Sex: ☐ M ☐ F ☐ X

Address: _____

Telephone: Cell: _____ Work: _____ Home: _____

Partner: _____ Next of Kin: _____

Household members (including ages): _____

Country of birth: _____ If not Canadian born, date of arrival: _____

Countries lived in (including dates): _____

TB History

Previous documented TST: ☐ Yes ☐ No

Date of TST: _____ Induration (mm): ____

Previous BCG: ☐ Yes ☐ No

Date of BCG: _____

Previous Active TB: ☐ Yes ☐ No

Treatment: ☐ Yes ☐ No

Details: _____

Previous Latent TB: ☐ Yes ☐ No

Treatment: ☐ Yes ☐ No

Details: _____

Signature: _____

NOTE: Adding your signature will lock the content of this section.

Medical History

Allergies:

_____

Do you have any of the following medical conditions?

HIV: ☐ Yes ☐ No ☐ Unknown

Cancer: ☐ Yes ☐ No

Diabetes: ☐ Yes ☐ No

Chronic renal failure: ☐ Yes ☐ No

Taking immunosuppressant drugs: ☐ Yes ☐ No

Current medication:

_____

Signature: _____

NOTE: Adding your signature will lock the content of this section.

Physician Information

Primary Health Care Provider (HCP): _____

Address: _____ City: _____ Postal Code: _____

Telephone: _____ Fax: _____

Consulting/Treating HCP: _____

Address: _____ City: _____ Postal Code: _____

Telephone: _____ Fax: _____

If you require this information in an alternate format, please call 1-800-267-7120 and press 0.

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Method of Detection

Name of Person Reporting: _____ Telephone: _____

Reporting Hospital/Facility: _____ Telephone: _____

☐ Symptoms ☐ Contact tracing ☐ Post mortem ☐ Other: _____

☐ Screening – Reason (school/employment/volunteer/immigration): _____

Signature: _____

NOTE: Adding your signature will lock the content of this section.

Symptoms

☐ Asymptomatic ☐ Cough > 3 weeks ☐ Hemoptysis ☐ Fatigue

☐ Fever ☐ Night sweats ☐ Weight loss ☐ Other: _____

Details of symptoms:

Signature: _____

NOTE: Adding your signature will lock the content of this section.

Risk Factors

☐ Correctional facility ☐ Homeless shelter ☐ Employment history (volunteer work)

☐ LTCF/Hospital ☐ Recent travel ☐ First Nations ☐ Known exposure/contact

☐ Smoking history: ☐ Yes ☐ No How long? _____

☐ Other: _____

Signature: _____

NOTE: Adding your signature will lock the content of this section.

Diagnostics

TST #1 date: _____ Given by: _____

Date read: _____ Result (mm): _____

TST #2 date: _____ Given by: _____

Date read: _____ Result (mm): _____

Chest x-ray ☐ Yes ☐ No Date: _____

CT scan ☐ Yes ☐ No Date: _____

AFB Specimen # _____ Collected: _____

AFB Specimen # _____ Collected: _____

AFB Specimen # _____ Collected: _____

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): _____

Signature: _____

NOTE: Adding your signature will lock the content of this section.

Adapted with permission from the Simcoe Muskoka District Health Unit.

Signature : _____

NOTE: Adding your final signature will lock the entire form.

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