TB Symptom Inquiry Questionnaire

Name: _____ DOB: _____ TB File #:_____
yyyy mm dd

Question the client as to whether he/she is experiencing any of the following symptoms.

1. Coughing daily? Y N
   a) how long have you had your cough? _____
   b) do you cough up any phlegm/sputum? Y
   c) If yes, what colour is the phlegm/sputum? _____

2. Fever or Chills? Y N
   a) If yes, how long? _____

3. Night sweats? Y N
   a) when did they start? _____
   b) how often do you have these episodes? _____
   c) do you have to change your bed sheets or nightclothes from sweats? Y N

4. Recent weight loss? Y N
   a) if yes, how much weight have you lost? _____
   b) over what period of time? _____

5. Fatigue or tiredness? Y N
   a) if yes, how long have you been feeling tired? _____

6. Loss of appetite? Y N
   a) if yes, when did you first notice it? _____

7. Pain in your chest? Y N
   a) if yes, describe pain and location _____

8. Problem with your liver? Y N
   a) if yes. describe what the problem is _____
   b) have you ever been told you had Hepatitis? Y N

9. Were you ever diagnosed with TB in the past? Y N
   a) if yes, when (year) and where (name of facility)? _____
   b) what treatment did you receive? _____

10. Is it possible you might be pregnant? Y N
    a) date of last menstrual period _____
    b) what kind of birth control are you currently using? _____

GUIDE: TB WORKLISTS

TB worklists are prepared by the TB Nurse based upon progressive follow-up for cases, contact tracings and sentinel surveillance of diagnostic testing and screening results for on reserve clients of Sioux Lookout Zone. TB worklists are generated every two months to coincide with your FNIHIS Immunization schedules

The worklist identifies the follow-up required per client, as outlined by the Ontario Region Tuberculosis Control Program. Headings and columns are explained below:

Clientno: This is an EpiInfo record number of the TB database. For program use only.

Mantoux:

- If a Mantoux is required to be done, the worklist month will be entered, e.g. "09/01" indicating that the client is due for a Mantoux in September, 2001.
- If "NEVER" is entered, the client has a history of previous TB infection or disease and TST should not be repeated.
- Blank field indicates no TST is required for this client at this time.
- Record Mantoux results on the FNIHIS immunization schedule and phone/fax significant results to TB Nurse (807) 737-4411 on the day of reading.

Symptom Inquiry:

- If a symptom inquiry is required, the worklist month will be entered, e.g. "09/01"
- Blank field indicates no symptom inquiry is required for this client at this time.
- An outline for the symptom inquiry follows on the next page (can be copied for use).

CXR: Chest x-ray

- If a chest x-ray is required, the worklist month will be entered, e.g. "09/01"
- Blank field indicates no radiology is required for this client at this time.

Sputa/GW: 3 early morning specimens of sputa or gastric washings for AFB and C&S

- If specimen collection is required, the worklist month will be entered, e.g. "09/01"
- Blank field indicates no specimens are required for this client at this time.

Bloodwork: Pre-INH serum for CBC, BUN, Creatinine, AST, ALT, Bilirubin, Alk Phosphatase
Please mark "Pre-INH" on requisition.

- If bloodwork is required, the worklist month will be entered, e.g."09/01"
- Blank field indicates no bloodwork is required for this client at this time.

Reason: Provides rationale for the follow-up requested by the worklist.

- **"INH treatment F/U", "F/U CXR, yearly X 2"** refer to program standards for treatment of latent TB infection.
- **"Pre-INH workup"** indicates that the client is recommended to take treatment for latent TB infection, and should progress through this assessment (CXR, symptom inquiry, bloodwork, physical assessment, medical review and prescription), be offered and be started on DOP **within 30 days of CXR date.**
- **"Required for assessment"** indicates that surveillance information has identified a concern about the TB status of a client.
- **"Requested by radiologist"** flags those clients who require repeat chest x-ray to clarify or confirm previous findings.
- **"Contact of a case"** and **"Contact of a convertor"** are linked to program standards for case and reverse contact follow-up.

PROCEDURE: **As requested actions are done, check off each field and fax to the TB Nurse as soon as completed or within one month, indicating problems affecting completion.** Fax: (807) 737-2141