Alberta Health Services

Tuberculosis Referral

To refer for Tuberculosis follow up recommendation, please complete all sections of this form, and return with x-ray report by fax or mail to one of the following sites according to client's residence.

☐ **Calgary Zone**
Calgary TB Services
#106, 2675 - 36th Street NE
Calgary, AB T1Y 6H6
Phone: 403-944-7660
Fax 403.291.9185

☐ **Edmonton Zone**
Edmonton TB Clinic
Aberhart Centre, Rm. 9232, 11402 University Ave.
Edmonton, AB T6G 2J3
Phone: 780-407-4550
Fax 780.407.4562

☐ **North, Central and South Zones, First Nations and Inuit Health**
Central TB Services
2nd Floor South Tower, 10030 107 St.
Edmonton, AB T5J 3E4
Phone: 780-735-1464
Fax 780.735.1195

This information collected under the Health Information Act (HIA) section 20 and as per the Public Health Act for the purpose of monitoring the health of Albertans, protecting and promoting the health of the public, preventing disease and injury, providing healthcare and other purposes authorized by the HIA. Questions about the collection, use and disclosure of this information can be directed to the supervisor of the designated zone offices listed above (see above for contact information).

Demographics

Referral Date *(yyyy-Mon-dd)*	Personal Health Number	Date of Birth *(yyyy-Mon-dd)*	Date of Death *(yyyy-Mon-dd)*
TB File #	Health Area/Health Centre	Zone Office	
Family Name	First Name	Middle Name	
Other Name(s)		Alias Type	Sex ☐ M ☐ F
Home Address	City/Town	Prov.	Postal Code
Phone	Other Phone	Occupation	
Name of contact person	Phone	Name of next of kin	Next of kin phone

Is an interpreter required? ☐ Yes, specify language required _____ ☐ No

Name of Family/Referring Physician		Address	
City/Town	Prov.	Postal Code	Phone
Copy to Other		Address	
City/Town	Prov.	Postal Code	Phone

Ethnicity

☐ Canadian-born Aboriginal *(select one of the following below)*
- ☐ First Nations registered, complete the following ►

Band of Origin	DIAND Number

- ☐ First nations, non-registered
- ☐ Metis
- ☐ Inuit

☐ Canadian-born non-Aboriginal

☐ Foreign-born, complete the following ►

Country of Birth	Date of arrival in Canada *(yyyy-Mon-dd)*

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History

Tuberculin Tests

MM	Date given *(yyyy-Mon-dd)*

IGRA/QFT *(if applicable)*

Result	Date performed *(yyyy-Mon-dd)*

Bacille Calmette-Guerin *(BCG)*

Has patient had BCG vaccine?
- ☐ Yes, complete the following ►
- ☐ No
- ☐ Unknown

Date of vaccine *(yyyy-Mon-dd)*

Does patient have BCG scar?
- ☐ Yes
- ☐ No

Has the patient had previous TB disease?
- ☐ Yes, complete the following ►
- ☐ No

Date of previous TB *(yyyy-Mon-dd)*

Province/Country

Did the patient receive previous TB treatment?
- ☐ Yes, complete the following ►
- ☐ No

Type of treatment
- ☐ Active
- ☐ Preventive

Province/Country

Medical Conditions *(check all that apply)*

- ☐ HIV/AIDS
- ☐ Chronic Corticosteroid use
- ☐ End-stage Renal Disease
  - ➥ Is the patient dialysis dependant? ☐ Yes ☐ No
- ☐ Head & Neck Cancer
- ☐ Organ Transplantation
- ☐ Diabetes
  - ➥ Is the patient insulin dependant? ☐ Yes ☐ No
- ☐ Silicosis
- ☐ Chemotherapy
- ☐ Other immunosuppressive condition *(specify)* _____
- ☐ None

Symptoms

- ☐ None
- ☐ Cough *(duration)* _____
  - ➥ Is there sputum? ☐ Yes ☐ No
- ☐ Night Sweats *(duration)* _____
- ☐ Haemoptysis *(duration)* _____
- ☐ Other *(specify and duration)* _____
- ☐ Weight Loss _____Kg
- ☐ Fever *(duration)* _____

Travel

If this person has travelled to a TB endemic country within the past two years, identify the purpose of travel and provide the dates. Check all that apply. [*Refer to Tuberculosis Prevention and Control Guidelines for Alberta (June 2010)]*

✓	Purpose of travel	Name of Country	Date from *(yyyy-Mon-dd)*	Date to *(yyyy-Mon-dd)*
☐	Work in health setting			
☐	Other work *(specify)*			
☐	Family visit			
☐	Tourism/Recreation			

Reason for Referral

Please check the **primary reason** if more than one applies.

☐ **Immigrant**

- ☐ Citizenship and Immigration Canada Medical Surveillance Referral
  - ☐ Landed *(external applicant)*
  - ☐ Visitor/Student/Working Visa
  - ☐ Landed Status *(internal applicant)*
  - ☐ Refugee
- ☐ Non-Citizenship and Immigration Canada Medical Surveillance Referral
  - ☐ Landed
  - ☐ Visitor/Student/Working Visa
  - ☐ Refugee
  - ☐ Household Review of Positive Reactors

☐ **Employment**, complete the following ▼

Occupation	Employer

Select one of the following workplace settings

- ☐ Acute Care Hospital
- ☐ High Risk Communal Setting
- ☐ Continuing Care Facility
- ☐ Other Employment *(specify)* _____
- ☐ Correctional Facility

[*Refer to Tuberculosis Prevention and Control Guidelines for Alberta (June 2010)]*

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Reason for Referral Continued

☐ **School Screening**
- ☐ Post-Secondary

☐ **Institutional Living**
- ☐ Continuing Care Facility
- ☐ Correctional Facility
- ☐ Residents of Other High Risk Communal Setting *(specify)* _____

[*Refer to Tuberculosis Prevention and Control Guidelines for Alberta (June 2010)*]

☐ **Symptoms** *(ensure the "Symptoms" section on page one is completed)*

☐ **Contact**, complete the following ▼

Contact Source Case Name or File Number	Last Contact Date *(yyyy-Mon-dd)*

Association with Source Case
☐ Close ☐ Casual ☐ Community ☐ Unkown

Contact Relation
☐ Household ☐ Non-Household

☐ **Travel to TB Endemic Country**, complete the following ► *(ensure the "Travel" section on page two is completed)*

☐ Pre-travel ☐ Post-travel

Name of Country

☐ **Immunosuppressed**
- ☐ HIV/AIDS
- ☐ Chronic Renal Failure
- ☐ Prolonged Corticosteroid Use
- ☐ TNF Inhibitors
- ☐ Organ Transplantation
- ☐ Silicosis
- ☐ Hematologic Malignancies

☐ **Other** *(specify)* _____

Comments

Radiology

☐ Chest X-Ray PA & Lateral

Return x-ray report to:

Health Area Stamp

Name of Health Nurse/Area	Signature	Date *(yyyy-Mon-dd)*