



Name: _____ First _____ Last _____ DOB: _____ (yyyy-mm-dd)
 PHN: _____ Community: _____

START HERE
Assess Risk

R1
☐ Risk conditions present.
 Symptoms of TB present?
S1
☐ Symptoms of TB present.
S2
☐ a. Refer to family physician or nurse practitioner for assessment (including CXR).
 Date: _____ (yyyy-mm-dd)
☐ b. Collect Sputum for AFB x 3.
 Date 1: _____ (yyyy-mm-dd)
 Date 2: _____ (yyyy-mm-dd)
 Date 3: _____ (yyyy-mm-dd)
☐ c. Refer to TB Services using the TB Services Referral form.
 Date: _____ (yyyy-mm-dd)
 TB File # _____

R2
☐ No risk conditions present.
 No further follow up necessary.

N1
☐ No symptoms of TB.
 Is client less than 60 years of age?
A1
☐ Yes.
 Client interested in taking prophylaxis?
P1
☐ Yes.
P2
☐ No.
T1
☐ No.
 Decision date: _____ (yyyy-mm-dd)
 Prophylaxis recommended, accepted and completed?
T2
☐ Yes.
 Date prophylaxis completed: _____ (yyyy-mm-dd)
 No further follow up necessary.

A2
☐ No.
 Follow up every 6-12 months OR with deterioration in health status. Use 'Follow-Up' screen algorithm.

High Risk Medical Conditions*:
☐ AIDS/HIV..... Date of Diagnosis: _____
☐ Silicosis..... Date of Diagnosis: _____
☐ Renal Failure Date of Diagnosis: _____
 - requiring dialysis and/or due to diabetes
☐ Carcinoma (head/neck)..... Date of Diagnosis: _____
☐ Haematological malignancies (Leukemia/Lymphoma)....Date of Diagnosis: _____
☐ Abnormal x-ray Date of Diagnosis: _____
 - fibronodular disease
 yyyy-mm-dd
Treatment with:
☐ Glucocorticoids (≥15mg/day for ≥1 month).....Date Initiated: _____
☐ Cyclosporine (Cyclosporine A).....Date Initiated: _____
☐ Tumor Necrosis Factor (TNF) alpha inhibitors.....Date Initiated: _____
☐ Anti-rejection medications for solid organ transplant....Date Initiated: _____
☐ Other(Specify): _____ Date Initiated: _____

Moderate Risk Medical Conditions*:
☐ Diabetes mellitus..... Date of Diagnosis: _____
Treatment with:
☐ Azathioprine (Imuran).....Date Initiated: _____
☐ Leflunomide.....Date Initiated: _____
☐ Other(Specify): _____ Date Initiated: _____

Date Algorithm completed: _____ (yyyy-mm-dd) Signature _____

☐ Faxed to Alberta Region TB Program - Date: _____ (yyyy-mm-dd)

Fax: 780-495-8070

*Other – Some chemotherapy drugs and treatments for psoriasis may qualify. Please consult TB services for more information and guidance.

Revision Date: April 2018

☐ Original to client file.

☐ Copy to binder/file for annual tracking.