

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

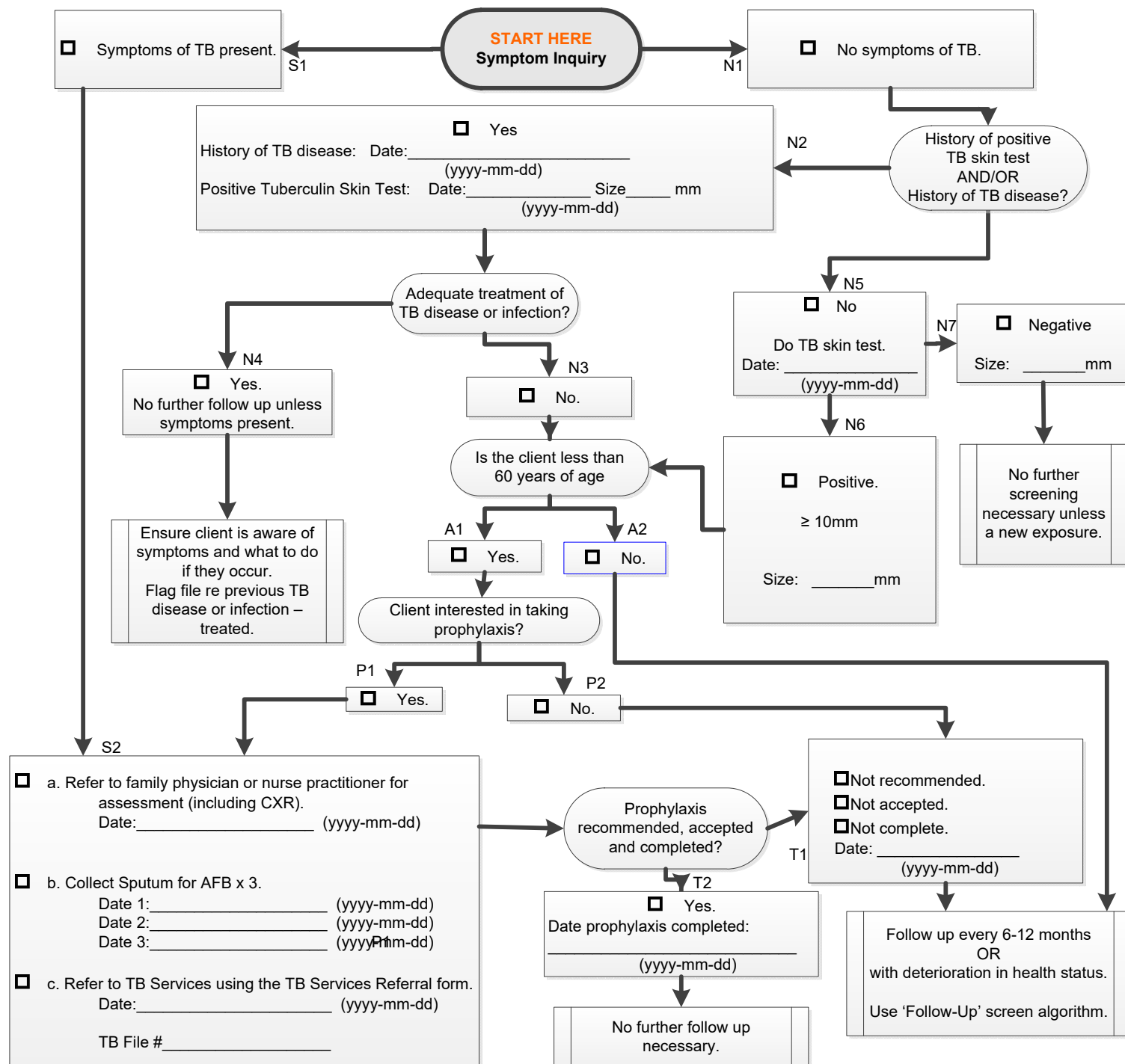
☐ Diabetes mellitus.....Date of Diagnosis: _____

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.

Canada