Health Canada / Santé Canada

ACTIVE TUBERCULOSIS (TB) REPORT FORM

First Nations and Inuit Health Branch – Ontario Region

Date CHN initially notified/aware of case: DD MMM YYYY

Date CD nurse notified: DD MMM YYYY

Case Number: ___ ___ -

Initials and date (YYYY/MMM/DD) each time form is updated and faxed to CD nurse: _____

_____

Client Demographics

Date of Birth: DD MMM YYYY

Age: _____

Gender: ☐ Male ☐ Female ☐ Other (specify): _____

Residency (at time of diagnosis): ☐ ON RESERVE ☐ OFF RESERVE

Place of residence (e.g. community): _____

Residency (check all that apply currently and in the last 12 months):

☐ ON RESERVE
☐ OFF RESERVE
☐ Home
☐ Boarding house/motel
☐ Correctional facility
☐ Other institution (e.g. nursing home)
☐ Street
☐ Other (specify): _____
☐ Rehab/ transition house
☐ Relative/friend's house
☐ Shelter

TB History

First episode of TB disease? ☐ Yes ☐ No ☐ Unknown

Previous diagnosis occurred in:

☐ Canada
☐ Other country (specify): _____

Year of previous diagnosis: YYYY

Previous treatment with (check all that apply):

☐ INH
☐ EMB
☐ RMP
☐ PZA
☐ Streptomycin
☐ Kanamycin
☐ Capreomycin
☐ Ofloxacin
☐ Ethionamide
☐ Rifabutin
☐ PAS
☐ Vit B_6
☐ No drugs prescribed
☐ Unknown
☐ Other (specify): _____

Previous treatment completed:

☐ Yes ☐ No ☐ Unknown

End date of previous treatment:

DD MMM YYYY

Has the client ever had a Tuberculin Skin Test (TST)? ☐ Yes ☐ No ☐ Unknown

Any positive TST results? ☐ Yes ☐ No ☐ Unknown

Date of first known positive: MMM YYYY

Result (in mm): _____

Any negative TST results? ☐ Yes ☐ No ☐ Unknown

Date of most recent negative: MMM YYYY

Result (in mm): _____

Has the client ever received the BCG vaccine? ☐ Yes ☐ No ☐ Unknown

Date BCG was given: MMM YYYY

Risk Factors

HIV Status: ☐ Unknown ☐ Test not offered ☐ Test refused ☐ Positive→ ☐ Negative→

Year of first positive result: YYYY

Year of most recent result: YYYY

Contact with person with active TB ***If yes, indicate month/year of contact:*** MMM YYYY	☐ Yes	☐ No	☐ Unknown
Diabetes mellitus (Type 1 or 2)	☐ Yes	☐ No	☐ Unknown
Chronic renal disease requiring hemodialysis	☐ Yes	☐ No	☐ Unknown
Lived in correctional setting in the last 2 years	☐ Yes	☐ No	☐ Unknown
Treatment with corticosteroids ***(e.g. prednisone > 15 mg/day)***	☐ Yes	☐ No	☐ Unknown
Previous abnormal chest x-ray (fibronodular disease)	☐ Yes	☐ No	☐ Unknown
Substance use (ETOH, tobacco, other)	☐ Yes	☐ No	☐ Unknown
Transplantation (related to immunosuppressive therapy)	☐ Yes	☐ No	☐ Unknown
Travel to high incidence TB country in last 2 years ***If yes, how long: _____ (in weeks)***	☐ Yes	☐ No	☐ Unknown
Other (specify): _____	☐ Yes	☐ No	☐ Unknown

Case Finding (i.e. How case was first identified)

☐ Symptoms compatible with site of disease
☐ Occupational screening
☐ Routine screening
☐ Post-mortem
☐ Incidental finding
☐ Contact investigation
Index Case #: _ _ - _ _ _ _ _ _
☐ Unknown
☐ Other (specify): _____

Health Canada / Santé Canada

Case Number: _____ -

Diagnostic/Clinical

Date of diagnosis: DD _____ MMM _____ YYYY _____ (e.g. Clinical, treatment start date, lab/CXR date, etc.)

Case Classification: ☐ New ☐ Reactivation ☐ Re-treatment *(See definitions in Guidelines for TB Report Forms)*

Site(s) of disease (Check all that apply): ☐ Unknown ☐ Pulmonary ☐ Miliary/disseminated ☐ Meningeal
☐ Lymph nodes ☐ Other (specify):_____

If pulmonary (i.e. infectious), indicate date the initial list of contacts was started: DD _____ MMM _____ YYYY _____

Was TB confirmed post-mortem? ☐ Yes ☐ No ☐ Unknown

Date of death: DD _____ MMM _____ YYYY _____

- ☐ TB was the cause of death
- ☐ TB contributed but was not the cause of death
- ☐ TB did not contribute to death

Chest x-ray: ☐ Normal ☐ Abnormal ☐ Not done ☐ Unknown

Result identified on chest x-ray: ☐ Cavitary ☐ Non-cavitary ☐ Unknown

Symptoms: ☐ Yes ☐ No ☐ Unknown

Symptom onset date: DD _____ MMM _____ YYYY _____

Date client first went to a primary care provider for TB related symptom(s): DD _____ MMM _____ YYYY _____

Indicate symptoms (check all that apply): ☐ Productive cough ☐ Hemoptysis ☐ Fever ☐ Weight loss
☐ Fatigue ☐ Anorexia ☐ Night sweats ☐ Other (specify):_____

Was client hospitalized for this episode of TB? ☐ Yes ☐ No ☐ Unknown

Admission date: DD _____ MMM _____ YYYY _____
Discharge date: DD _____ MMM _____ YYYY _____
Duration of airborne isolation in hospital (days): _____

Was client advised to self-isolate at home?
☐ Yes ☐ No ☐ Unknown
Duration of self-isolation at home (days): _____

Laboratory Results

Were any specimens sent to the laboratory for culture? ☐ Yes ☐ No ☐ Unknown

	Specimen #1	Specimen #2	Specimen #3
Specimen type:			
Specimen source:			
Date collected:	DD _____ MMM _____ YYYY _____	DD _____ MMM _____ YYYY _____	DD _____ MMM _____ YYYY _____
Date received by lab:	DD _____ MMM _____ YYYY _____	DD _____ MMM _____ YYYY _____	DD _____ MMM _____ YYYY _____
Microscopy (AFB)	☐ Pos (#:) ☐ Neg ☐ Unknown / Indeterm. ☐ Not done	☐ Pos (#:) ☐ Neg ☐ Unknown / Indeterm. ☐ Not done	☐ Pos (#:) ☐ Neg ☐ Unknown / Indeterm. ☐ Not done
Date reported by lab:	DD _____ MMM _____ YYYY _____	DD _____ MMM _____ YYYY _____	DD _____ MMM _____ YYYY _____
Nucleic Acid Amplification (NAA) (e.g. Amplified Mycobacterium Tuberculosis Direct (AMTD) Test)	☐ Pos ☐ Neg ☐ Not done ☐ Pending	☐ Pos ☐ Neg ☐ Not done ☐ Pending	☐ Pos ☐ Neg ☐ Not done ☐ Pending
Culture Results:	☐ Pos ☐ Neg ☐ Unknown / Indeterm. ☐ Pending	☐ Pos ☐ Neg ☐ Unknown / Indeterm. ☐ Pending	☐ Pos ☐ Neg ☐ Unknown / Indeterm. ☐ Pending
Date reported by lab:	DD _____ MMM _____ YYYY _____	DD _____ MMM _____ YYYY _____	DD _____ MMM _____ YYYY _____

Antibiotic Resistance

Indicate below only if lab results confirmed susceptibility/resistance: ☐ Results Unknown/Not Available ☐ Pending

Susceptible: ☐ INH ☐ EMB ☐ RMP ☐ PZA ☐ Others (specify): _____

Resistant: ☐ INH ☐ EMB ☐ RMP ☐ PZA ☐ Others (specify): _____

Treatment Details

TREATMENT START DATE: DD _____ MMM _____ YYYY _____

Was Directly Observed Therapy (DOT) applied? ☐ Yes ☐ No ☐ Unknown

Drugs prescribed initially? (Check all that apply) ☐ Yes ☐ No drugs prescribed ☐ Unknown

☐ INH ☐ EMB ☐ RMP ☐ PZA ☐ Streptomycin ☐ Kanamycin ☐ Rifabutin ☐ Ofloxacin ☐ Ethionamide ☐ Capreomycin ☐ PAS ☐ Vit B_6 ☐ Other(specify): _____

Nurse Identification

First Name:	Last Name:	Signature: