Health Canada / Santé Canada

LATENT TUBERCULOSIS INFECTION (LTBI) REPORT FORM

First Nations and Inuit Health Branch – Ontario Region

Date first faxed to CD nurse: D D M M M Y Y Y Y

Initials and date (dd/mmm/yyyy) each time form is revised and faxed to CD nurse: _____

Episode Number:

L _____ - _____

Client Demographics

First Name: | Last Name:

Date of Birth: D D M M M Y Y Y Y

Age (in years, or months if <1 year):_____

Gender: ❒ Male ❒ Female ❒ Unknown ❒ Other (specify): _____

Residency (at time of tuberculin skin test): ❒ ON RESERVE ❒ OFF RESERVE

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

Previous and current residency: (check all that apply currently and in the last 12 months)

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

Tuberculin Skin Test

Any previous negative TST? ❒ Yes ❒ No ❒ Unknown If yes, date: D D M M M Y Y Y Y

Any previous positive TST? ❒ Yes ❒ No ❒ Unknown If yes, date: D D M M M Y Y Y Y

Reason for testing (check all that apply):

❒ Contact Tracing ❒ Routine Screening ❒ Risk factors for Active TB ❒ Other: _____

If Contact Tracing, indicate date client added to contact list of index case: D D M M M Y Y Y Y

Test result (in mm):_____ **Date test read:** D D M M M Y Y Y Y

Treatment Details

Assessment of risk for active TB: ❒ High ❒ Moderate ❒ Low

Referred to Physician? ❒ Yes ❒ No ❒ Unknown Date referred: D D M M M Y Y Y Y

Client assessed for active TB? ❒ Yes ❒ No ❒ Unknown *(If yes and active TB confirmed, complete Active TB form.)*

Prophylaxis recommended? ❒ Yes ❒ No ❒ Unknown

Prophylaxis started? ❒ Yes ❒ No ❒ Unknown Date started: D D M M M Y Y Y Y

Drugs prescribed (check all that apply);

- ❒ Isoniazid (INH) Frequency: _____ Duration (months): _____
- ❒ Rifampin (RMP) Frequency: _____ Duration (months): _____
- ❒ Other: _____ Frequency: _____ Duration (months): _____

Prophylaxis Completed? ❒ Yes ❒ No ❒ Unknown

Date prophylaxis completed: D D M M M Y Y Y Y

Major mode of treatment:

- ❒ Directly Observed Preventive Therapy (DOPT)
- ❒ Daily, self-administered
- ❒ Other (specify):_____
- ❒ Unknown

Risk Factors

HIV: ❒ Positive ❒ Negative ❒ Test refused ❒ Test not offered ❒ Unknown

If positive, year of 1st positive test
If negative, year of most recent test Y Y Y Y

Contact with person with active TB If yes, indicate month/year of contact: M M M Y Y Y Y	❒ Yes	❒ No	❒ Unknown
Diabetes mellitus (Type 1 or 2)	❒ Yes	❒ No	❒ Unknown
End-stage renal disease requiring hemodialysis	❒ Yes	❒ No	❒ Unknown
Lived in correctional setting at any time in the last 2 years	❒ Yes	❒ No	❒ Unknown
Treatment with corticosteroids *(e.g. prednisone > 15 mg/day or equivalent)*	❒ 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

Nurse Identification		
First Name:	**Last Name:**	**Signature:**