Prince Edward Island CANADA Health and Wellness

Positive Tuberculin Skin Test Report

Case ID:

1. CLIENT INFORMATION:			
PHN:	Sex ☐ Male ☐ Female	Date of birth:	Age ____ years ____ months (if under 2 yrs)
Last name:	First name:	Email:	
Parent/Guardian (if applicable):			
Address:	City/town:	Postal Code:	
Tel: Alt. Tel:	Family Dr.:	Tel:	
Ethnicity:	Employer:	Tel:	
Country of Birth:	Date of Immigration (if applicable):		

2. REASON FOR TESTING:	
☐ 65 years of age and under at a LTC facility	☐ Diagnosis of Medical Condition
☐ Entry into Educational Program	☐ Working in TB Endemic Area
☐ Health Care Worker Screening	☐ Pre-Medication
☐ Other, If yes, specify	

3. HAS CLIENT RECEIVED BCG?				
☐ No	☐ Yes	If **yes**,	At what age?	Where (country)?

4. HAS CLIENT BEEN EXPOSED TO TB IN THE PAST?				
☐ No	☐ Yes	If **yes**,	When?	Where (country)?

Circumstances of Exposure:

Was the client treated?	☐ No	☐ Yes	If **yes**, describe:

5. TUBERCULIN SKIN TEST RESULTS	
Initial TST	**Second TST (if needed)**
Date planted:	Date planted:
Date read:	Date read:
Result (induration only, not redness): mm	Result (induration only, not redness): mm

6. RISK FACTORS FOR REACTIVATION	
☐ HIV Infection	☐ Abnormal Chest X-ray: granuloma
☐ AIDS	☐ Abnormal Chest X-ray: fibronodular disease
☐ Diabetes Mellitus	☐ Carcinoma of Head or Neck
☐ Cigarette smoker (> 1 pack/day)	☐ Recent TB infection (TST conversion ≤ 2 years ago)
☐ Transplantation (requiring immune-suppressant therapy)	☐ Tumor Necrosis Factor (TNF) alpha inhibitors (infliximab/Etanercept)
☐ Treatment with glucocorticoids	☐ Silicosis
☐ Underweight (< 90% ideal body weight or a body mass index (BMI) ≤ 20)	☐ Young age when infected with TB (i.e. 0 - 4 years)
☐ Chronic renal failure requiring hemodialysis	☐ Other:

7. REFERRED FOR CHEST X-RAY AND REQUISITION GIVEN TO CLIENT		
☐ No	☐ Yes	If **no**, comment:

NOTE: IT IS RECOMMENDED THAT ANY CLIENT WITH A POSITIVE TST HAVE A CHEST X-RAY IF ONE HAS NOT BEEN DONE IN THE PAST 6 MONTHS

Does client require a copy of their chest x-ray?	☐ No	☐ Yes
Does client require a copy of their IGRA result (if done)?	☐ No	☐ Yes

If yes, CPHO will send a copy to the HCP to forward to the client. Date sent:

Additional Comments:

HCP Completing Form:	Date:

Please return completed form to the CPHO – FAX: 902-620-3354,
Mail: 16 Fitzroy St. 2nd Fl Sullivan, PO Box 2000 Charlottetown, PE, C1A 7N8

CPHO Nurse:	**Date:**