

POSITIVE TB SKIN TEST (TST) / IGRA REPORTING FORM (April 2023)

Public Health Services
www.hamilton.ca/tuberculosis
 Phone: 905-546-2063
 Fax: 905-546-4078



Please complete and fax this form and chest x-ray report to 905-546-4078 within 7 days.

Patient's Last Name, First Name Middle Name	Date of Birth <small>(dd/mmm/yyyy)</small>	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Other
Address, City, Postal Code	Home Phone Number	Cell Phone Number
Born in Canada <input type="checkbox"/> Yes - Province: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes - identify as: <input type="checkbox"/> First Nation <input type="checkbox"/> Metis <input type="checkbox"/> Inuit <input type="checkbox"/> Other Indigenous	Country of Birth	Date of Arrival <small>(dd/mmm/yyyy)</small>

Reason for Test Routine screening (includes volunteer, school, work) Medical Immigration
 Symptoms - Specify: _____ Other - Specify: _____

History of Positive TST: No Yes **Note:** A person with documented positive TST in mm induration does **not** require further TSTs. Proceed to chest x-ray and follow-up.

First TST	Second TST	IGRA	BCG Vaccine Hx
Date Planted: _____ <small>(dd/mmm/yyyy)</small>	Date Planted: _____ <small>(dd/mmm/yyyy)</small>	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> N/A Please fax IGRA result along with this form	<input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes - Year: _____
Date Read: _____ <small>(dd/mmm/yyyy)</small>	Date Read: _____ <small>(dd/mmm/yyyy)</small>		
Result: _____ mm induration	Result: _____ mm induration		

Positive TST: ✓ 10 mm or more is considered positive for most people
 ✓ 5 mm or more may be considered positive in specific situations listed in the Canadian TB Standards, 8th Ed., [Chapter 4](#), Table 1

Patients with positive TST require: ✓ Symptom assessment and physical exam
 ✓ **Chest x-ray - Date:** _____
 ✓ Additional testing (e.g. sputum for AFB and culture) as deemed necessary

Symptom Assessment

Asymptomatic Symptomatic - Specify: cough fever night sweats fatigue other: _____

If symptomatic or chest x-ray indicates TB disease: ✓ Instruct patient to isolate at home (provide masks)
 ✓ Collect 3 sputum specimens at least 1 hour apart
 ✓ Report immediately to public health at 905-546-2063

Risk Factors for TB Disease Progression

Check all that apply:

<input type="checkbox"/> No risk factors <input type="checkbox"/> HIV infection <input type="checkbox"/> Close contact of an infectious TB case (within 3 years) <input type="checkbox"/> Age when infected - under 5 years <input type="checkbox"/> Silicosis <input type="checkbox"/> Chronic renal failure / hemodialysis <input type="checkbox"/> Transplant recipient <input type="checkbox"/> Fibronodular disease	<input type="checkbox"/> Receiving immunosuppressive drugs <input type="checkbox"/> Biologics <input type="checkbox"/> Moderate to high dose steroids <input type="checkbox"/> Cancer (lung, sarcoma, leukemia, lymphoma or gastrointestinal) <input type="checkbox"/> Granuloma on chest x-ray <input type="checkbox"/> Diabetes <input type="checkbox"/> Alcohol use (3 or more drinks/day) <input type="checkbox"/> Tobacco cigarette use (1 or more packs/day) <input type="checkbox"/> Underweight (less than 90% ideal body weight)
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Note: Refer to The Online TST/IGRA Interpreter Tool at <http://www.tstin3d.com> to assess risk for active TB disease.

Health Education and Follow-Up

<input type="checkbox"/> Reviewed signs & symptoms of active TB and when to seek health care	<input type="checkbox"/> Referred to family physician
<input type="checkbox"/> TB information provided - available at www.hamilton.ca/tuberculosis	<input type="checkbox"/> Prophylaxis discussed
<input type="checkbox"/> Referred to TB Clinic (Phone: 905-522-1155 x34198 Fax: 905-525-5806)	<input type="checkbox"/> Prophylaxis refused

Health Care Provider Name: _____ **Date:** _____
Address: _____ **Phone:** _____ **Fax:** _____