

Citizenship and Immigration Canada (CIC) has placed your patient on medical surveillance. Medical Surveillance is required for individuals, who during their immigration medical examination were found to have previously treated TB, pulmonary TB infection, extra-pulmonary TB, recent household/close contact with a person with TB disease or TB infection with a high risk of reactivation.

Complete the attached form and fax to Lakelands Public Health at 905-885-9554. Forward all additional test results as they become available.

During the appointment, complete the following:

- **Clinical evaluation and TB symptom assessment:** Review the patient's history of tuberculosis, previous tuberculosis treatment, family history of tuberculosis, history of contact with respiratory tuberculosis, and current TB symptoms.
- **Chest x-ray:** Complete a chest x-ray and attach report to this form.
- **Sputum specimens:** Collect sputum specimens if the client has TB disease symptoms, or if clinically indicated. Collect at least one specimen, preferably three ≥ 1 hr apart. Sputum may be induced if needed.

Testing & Treatment Considerations

- **TST/IGRA:** TST or IGRA is generally not required for medical surveillance, but health care providers may consider testing for high-risk clients based on TB exposure, risk of reactivation, and suitability for preventive treatment.
- **Treatment Guidelines:** Refer to the Canadian TB Standards, 8th edition. Consider treatment for TB infection for high-risk clients unless adequate prior treatment for TB infection or TB disease is documented. Rule out TB disease before prophylaxis. If sputum specimens were collected, forward culture results before TB medication is provided.

Payment

- Medical examination and relevant tests are eligible for payment through OHIP or the Interim Federal Health Plan.
 - Please note: IGRA blood work is not covered by OHIP.
- Patients who do not have OHIP or Interim Federal Health Plan coverage, such as visitors, are billed directly.
- Uninsured patients for whom TB disease is suspected may be eligible for coverage through the TB-UP program. Call Lakelands Public Health at 249-588-0087 to determine eligibility.

Resources

- Lakelands Public Health Infectious Diseases Program Nurse: 249-588-0087.
- Canadian TB Standards: linksmedicus.com/news/canadian-tuberculosisstandards-8th-edition/
- Public Health Agency of Canada: canada.ca/en/public-health/services/diseases/tuberculosis.html
- BCG Atlas: bcgatlas.org/
- TST in 3D: The Online TST/IGRA Interpreter: tstin3d.com/en/calc.html

Client Information			
Name:		Gender: ☐ M ☐ F ☐ Other	
Date of Birth: YYYY/MM/DD	Phone Number:		OHCN:
Address:			
Occupation:		Country of Origin:	
Reason for Testing			
☐ Routine (work/school/volunteer) ☐ Targeted (HIV+/inmate etc.) ☐ Contact of a TB Disease case ☐ Suspected Atypical Mycobacterium ☐ TB Disease *Call Public Health* ☐ Other:			
TB History and Previous Treatment		Risk Factors (Including but not limited to)	
History of TB Disease OR TB Infection	☐ Yes ☐ No	☐ Recent immigration (≤last 2yrs)	
Known exposure to TB Disease	☐ Yes ☐ No	☐ Close contact with TB Disease case (< last 5 years)	
Previously treated for TB Disease	☐ Yes ☐ No	☐ Diabetes	
Previously treated for TB Infection	☐ Yes ☐ No	☐ Immunosuppressive therapy/disease	
Previous positive TB Skin Test	☐ Yes ☐ No	☐ Cancer	
BCG vaccination	☐ Yes ☐ No ☐ Unsure	☐ HIV	
If YES to any of the above, provide details:		☐ Chronic kidney disease/dialysis	
		☐ Silicosis	
		☐ Heavy alcohol or tobacco use	
		☐ Organ/Bone Marrow transplant	
TB Symptom Assessment			
Onset Date: YYYY/MM/DD			
☐ None ☐ Productive Cough ☐ Low-grade Fever ☐ Night Sweats ☐ Lack of Appetite ☐ Fatigue ☐ Chest Pain ☐ Hemoptysis ☐ Chills ☐ Significant Unexplained Weight Loss			
Chest X-ray			
Status: ☐ Not Done ☐ Completed: YYYY/MM/DD		*Fax Results*	
Results: ☐ Normal ☐ Abnormal but not suggestive of TB ☐ Abnormal ☐ Pending			
Sputum for AFB Smear and Culture			
Collect if symptomatic or otherwise indicated (e.g. suspicious/abnormal CXR) *Fax Results*			
#1	Collected Date: YYYY/MM/DD	Result:	
#2	Collected Date: YYYY/MM/DD	Result:	
#3	Collected Date: YYYY/MM/DD	Result:	
Follow-Up and Referral			
Client notified of results		☐ No ☐ Yes, Date/Details:	
Follow-up recommended (e.g. additional x-ray etc.)		☐ No ☐ Yes, Date/Details:	
Has a referral been made		☐ No ☐ Yes, Specialists Name:	
Treatment prescribed		☐ No ☐ Yes ☐ Contraindicated ☐ Refused, *Fax Prescription*	
Liver function/baseline labs ordered (If treatment considered)		☐ Not ordered ☐ Pending ☐ Complete, *Fax Results*	
Care Provider Information			
Name:		Role: ☐ NP ☐ MD ☐ Other:	
Phone Number:		Fax Number:	
Signature:			