

Client Information		
Name:		Gender: ☐ M ☐ F ☐ Other
Date of Birth: YYYY/MM/DD	Phone Number:	OHCN:
Address:		
Occupation:	Country of Origin:	
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 active TB 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		
TB Skin Test (TST)/Interferon Gamma Release Assay (IGRA) Testing		
TST Date	Date Read	Induration
YYYY/MM/DD	YYYY/MM/DD	mm
YYYY/MM/DD	YYYY/MM/DD	mm
IGRA Serology ☐ Not Ordered : ☐ Negative ☐ Positive ☐ Other:		
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 (i.e. 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	
Follow-up recommended (e.g. x-ray etc.)	☐ No ☐ Yes, Date/Details:	
Has a referral been made	☐ No ☐ Yes, Specialists Name:	
Treatment prescribed	☐ No ☐ Yes ☐ Contraindicated ☐ Refused, *Fax Prescription*	
Baseline labs ordered & 1m post-treatment initiation labs	☐ Not ordered ☐ Pending ☐ Complete *Fax Results*	
Counselling regarding TBI and TBD completed	☐ No ☐ Yes	
Impression	☐ TBI ☐ Suspected TBD ☐ No TBI or TBD ☐ Pending	
Care Provider Information		
Name:	Role: ☐ NP ☐ MD ☐ Other:	
Phone Number:	Fax Number:	
Signature:		