York Region

Community and Health Services Department
Infectious Diseases Control Division

NOTIFICATION OF NEW ACTIVE OR REACTIVATED TUBERCULOSIS CASE

Please return completed form to: **York Region Community and Health Services - TB Program** **Attn**:_____
9060 Jane Street, 5th Floor, Vaughan, ON L4K 0G5 **Fax: 905-895-5450, 1-844-209-4389**
If there are any questions, please contact the York Region Tuberculosis Control Program. **Tel: 1-877-464-9675, ext. 76000**

PATIENT IDENTIFICATION

Last Name	First Name	Sex ☐ M ☐ F	Health Card #
Street Address	Town/City	Postal Code	Birth Date ___/___/___ Yr. Mo. Day
Home Phone	Other Phone	Marital Status ☐ Single ☐ Marr. ☐ C.L. ☐ Sep. ☐ Wid.	
Country of Birth	Date of Arrival ___/___/___ Yr. Mo. Day	Language(s) Spoken	Occupation / Work Phone

Hospital Admission? ☐ Yes ☐ No Name of Hospital _____
Admission Date ___/___/___ Yr. Mo. Day Discharge Date ___/___/___ Yr. Mo. Day

DIAGNOSIS

Is client/family aware of diagnosis? ☐ Yes ☐ No

Respiratory

☐ Pulmonary
- ☐ Far Advanced
- ☐ Moderately Advanced
- ☐ Minimal

☐ Laryngeal
☐ Pleurisy
☐ Other Respiratory
Specify _____
☐ Primary

Non-Respiratory

☐ Miliary (disseminated)
☐ Other, spec. site _____

METHOD OF DETECTION

☐ Symptoms ☐ Contact ☐ Routine
☐ Immigration Medical Surveillance
☐ Other *(specify)* _____

TUBERCULIN TEST

Mantoux *(specify result)* Date

HISTORY

☐ New Active Case
☐ Reactivated Case
Year of first active episode _____
Country of first active episode _____

HIV TEST

HIV Test Ordered? ☐ Yes ☐ No ☐ Refused
If Yes ...
Result _____ Date ___/___/___ Yr. Mo. Day

LABORATORY STATUS

	Microscopy				Culture			
	Sputum	BAL	Other (specify)		Sputum	BAL	Other (specify)	
NEG.								
POS.								
NOT DONE								

PATHOLOGY RESULTS (if applicable)

_____ mm (diameter induration) Read ___/___/___ Yr. Mo. Day	

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SYMPTOMS

Onset Date of Symptoms ___/___/___ Yr. Mo. Day

Date of Diagnosis ___/___/___ Yr. Mo. Day

RADIOLOGY RESULTS

☐ Normal ☐ Not Done ☐ Unknown

☐ Abnormal

☐ Cavitary ☐ Non-Cavitary ☐ Not Specified

Date of Test _____/____/____ Yr. Mo. Day

Please attach radiology reports done within last 3 months.

What is the client's level of infectivity?

☐ Low ☐ Moderate ☐ High

MORTALITY

Was this case discovered after death? ☐ Yes ☐ No

If Yes ... Date of Death ___/___/___ Yr. Mo. Day

☐ TB - Cause of Death

☐ TB - Contributed But Not Cause Of Death

☐ TB - Incidental Finding

Next of Kin _____

Tel. # _____

PRESENT DRUG REGIME

☐ ISONIAZID ____ mg ☐ OTHER _____

☐ RIFAMPIN ____ mg ☐ OTHER _____

☐ ETHAMBUTOL ____ mg ☐ OTHER _____

☐ PYRAZINAMIDE ____ mg ☐ OTHER _____

☐ PYRIDOXINE (B6) ____ mg ☐ OTHER _____

Date Started ___/___/___ Yr. Mo. Day

Drug Resistance

☐ Yes ☐ No ☐ Unknown

Specify _____

FAMILY PHYSICIAN

Name _____

Address _____

_____

Tel. # _____

TREATING PHYSICIAN *(Please Print)*

Name _____

Address _____

_____

Tel. # _____

Physician Signature _____

Date _____

REMARKS (e.g. other health problems)

This information is being collected under the authority of the *Health Protection and Promotion Act,* R.S.O. 1990, c.H.7 for the purpose of obtaining and maintaining a medical history to provide or assist in the provision of treatment for tuberculosis, for the purpose of case management, client follow up, monitoring and contact tracing,

for the purpose of public health administration and for the provision of statistical data to the Ministry of Health and Long Term Care. This information will be retained, used, disclosed and disposed of in accordance with the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3. Any questions regarding this collection may be directed to the Manager of Tuberculosis Control, 9060 Jane Street, 5th Floor, Vaughan, Ontario L4K 0G5 (905) 830-4444 extension 73065.