

## Referral for Medical Follow-up Tuberculosis Control Program

Please return by fax to York Region Tuberculosis Control Program: 1-844-209-4389 or 905-895-5450

Date sent:	Reason for referral:	Contact	Positive TB test	Positive IGRA test
Patient's surname:		Patient's given name:		
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Birth date:	Country of birth:		
Healthcard #:		Phone #:		
Address:		City:	Postal code:	
Index case information:				

### PHYSICIAN TO COMPLETE THE FOLLOWING

<p style="text-align: center;"><b>History</b></p> <p><b>1. Any previous TST/IGRA results</b>  Result: _____ mm      Date: _____  Result: _____ IU/mL      Date: _____</p> <p><b>2. Patient's risk factors to develop TB disease</b>  <input type="checkbox"/> Transplantation      <input type="checkbox"/> Underweight (less than 90% ideal body weight)  <input type="checkbox"/> Silicosis  <input type="checkbox"/> Renal/Liver Disease      <input type="checkbox"/> On treatment with glucocorticoids  <input type="checkbox"/> Carcinoma of head and neck      <input type="checkbox"/> Previous TB exposure  <input type="checkbox"/> Recent TB infection (≤ 2 years)      <input type="checkbox"/> Diabetes  <input type="checkbox"/> HIV/AIDS      <input type="checkbox"/> Tumor Necrosis Factor  <input type="checkbox"/> Other: _____</p> <p><b>3. Has the patient lived/travelled for longer than three months to a TB-endemic country?</b>  <input type="checkbox"/> Yes, Country: _____ Date: _____  <input type="checkbox"/> No</p> <p><b>4. Has patient ever worked, volunteered or lived in:</b>  <input type="checkbox"/> Shelter    <input type="checkbox"/> Nursing home    <input type="checkbox"/> Correctional facility  <input type="checkbox"/> Psychiatric institution    <input type="checkbox"/> Refugee camp</p> <p style="text-align: center;"><b>TB Skin Test/IGRA result</b></p> <p><input type="checkbox"/> TST (Date Planted): _____  Date Read: _____ Result: _____ mm  <input type="checkbox"/> IGRA (QFT): _____  Date: _____ Result: _____ IU/mL  <b>(If the TST or IGRA was previously, or is currently, positive, a chest X-ray is required.)</b></p>	<p style="text-align: center;"><b>Chest X-Ray</b></p> <p><b>(If a chest x-ray was done within the last six months, provide a copy of the radiology report.)</b>  Date of chest x-Ray: _____  Result: <input type="checkbox"/> Normal    <input type="checkbox"/> Not done    <input type="checkbox"/> Unknown  Abnormal— (<input type="checkbox"/> Cavitory <input type="checkbox"/> Non-Cavitory <input type="checkbox"/> Not specified)</p> <p><b>Sputum examination is required if the patient is symptomatic or has an abnormal chest x-ray.</b>  Was sputum collected? <input type="checkbox"/> Yes    <input type="checkbox"/> No  Results: _____ Date: _____  Symptoms: _____</p> <p><b>Was a referral made for further investigation?</b>  <input type="checkbox"/> Yes, Name: _____ Phone: _____  <input type="checkbox"/> No</p> <p style="text-align: center;"><b>LTBI Treatment</b></p> <p><b>Active TB must be ruled out before starting LTBI treatment.</b>  Is active TB ruled out? <input type="checkbox"/> Yes <input type="checkbox"/> No  Was LTBI treatment initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prescription provided to patient: <input type="checkbox"/> Yes <input type="checkbox"/> No  Prescription faxed to one of the four pharmacies listed on the bottom of this form: <input type="checkbox"/> Yes (fill in below) <input type="checkbox"/> No  <input type="checkbox"/> Isoniazid _____ mg    <input type="checkbox"/> Rifapentine(3HP) _____ mg  <input type="checkbox"/> Rifampin _____ mg    <input type="checkbox"/> Pyridoxine(B6) _____ mg  <input type="checkbox"/> Other _____ mg  Proposed length of treatment:  <input type="checkbox"/> 3 months    <input type="checkbox"/> 4 months    <input type="checkbox"/> 6 months    <input type="checkbox"/> 9 months  <input type="checkbox"/> other: _____</p>
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York Region has four pharmacies that dispense free TB medication. ONLY send patients to one of the following:

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| • Guardian at Southlake (Southlake Regional Health Centre)                    | 905-830-5988 |
| • Dales Pharmacy (Markham-Stouffville Hospital)                               | 905-471-1234 |
| • Pure Health Pharmacy (Cortellucci Vaughan Hospital)                         | 365-922-3200 |
| • Pure Health Pharmacy (Mackenzie Health Richmond Hill)                       | 905-883-7500 |
| • Oak Valley Health Outpatient Pharmacy (Inside Markham Stouffville Hospital) | 905-472-7624 |

Physician's name/stamp: \_\_\_\_\_ Date: \_\_\_\_\_ Physician's signature: \_\_\_\_\_

<b>TB Office use only</b>	
<input type="checkbox"/> iPHIS	Contact Investigator: _____

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, case management, client follow up, monitoring and contact tracing, public health administration and for the provision of data to the Ministry of Health and Public Health Ontario. This information will be retained, used, disclosed and disposed of in accordance with the *Personal Health Information Protection Act*, 2004. Any questions regarding this collection may be directed to the Manager of Tuberculosis Control, 9060 Jane Street, 5th Floor, Vaughan ON L4K 0G5, 1-877-464-9675 extension 73065.