York Region

TUBERCULOSIS CONTROL PROGRAM

Community and Health Services Department
Public Health Branch

Document Name: Appendix 5 K- Referral for Medical Follow Up form - revised 4/8/14

REFERRAL FOR MEDICAL FOLLOW-UP OF:

☐ Contact ☐ Positive TB test ☐ HIV Positive

PLEASE COMPLETE AND RETURN 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's Surname: Given Names:	Health Card #:	Sex: M ☐ F ☐
Current Address:	Town/City:	Postal Code:
Home Phone: / Cell Phone:	Birth Date: _____/_____/_____ *Year Month Day*	
Country of Birth: / Date of Arrival:	Language Spoken:	

PHYSICIAN TO COMPLETE ALL OF THE FOLLOWING:

Index Case Information:

HISTORY

1. Any previous Mantoux skin test results:

   Reading: _____mm Date: _____

   Reading: _____mm Date: _____

2. Does the client have risk factors to develop TB disease?

   ☐ Transplantation ☐ **Diabetes**
   ☐ Silicosis ☐ **Tumor Necrosis Factor**
   ☐ Renal/Liver Disease ☐ **HIV/AIDS**
   ☐ Carcinoma of head and neck
   ☐ Recent TB infection (≤ 2 years)
   ☐ Underweight (less than 90% ideal body weight)
   ☐ On treatment with glucocorticoids
   ☐ Other _____

3. Has the client received BCG in the past?

   ☐ Yes ☐ No ☐ Unknown

   Date: _____

4. Has the client lived/travelled for longer than 3 months to a TB endemic country? ☐ Yes ☐ No

   Country: _____ Date: _____

5. Has the client ever worked, volunteered or lived in:

   ☐ Shelter ☐ Nursing home
   ☐ Correctional Facility ☐ Psychiatric institution
   ☐ Refugee Camp

6. Other than this exposure, has the client ever been exposed to TB? ☐ Yes ☐ No

TB SKIN TEST:

Medically necessary TB skin tests are covered under OHIP. Medically necessary tests include those for people identified as contacts of a TB case.

☐ **TB Skin Test: _____**

Reading: _____mm Date: _____

☐ **TB Skin Test: _____**

Reading: _____mm Date: _____

If the tuberculin skin test was or is currently positive, a chest x-ray is required.

CHEST X-RAY:

If done, provide copy of radiology report.

Date of X-Ray: _____/_____/_____
Year Month Day

Result: ☐ Normal ☐ Not Done ☐ Unknown
☐ Abnormal ☐ Cavitary
☐ Non-Cavitary
☐ Not Specified

Sputum examination is required if client is symptomatic or has an abnormal chest x-ray.

WERE SPUTUMS SENT? ☐ Yes ☐ No

Results: _____ Date: _____

SYMPTOMS:

Was referral made for further investigation? ☐ Yes ☐ No

Name: _____

Telephone: _____

Was Prophylaxis Initiated? ☐ Yes ☐ No

Date Started: _____

☐ isoniazid _____mg ☐ pyrazinamide _____mg

☐ rifampin _____mg ☐ ethambutol _____mg

Physician's Stamp _____ Date _____ Physician's Signature

In York Region, TB medication is available at no cost from:

Health Plus Pharmacy (Mackenzie Health Richmond Hill)	(905) 883-7500
Dales Pharmacy (Markham-Stouffville Hospital)	(905) 471-1234
Centric Pharmacy (Southlake Regional Health Centre)	(905) 830-5988

TB OFFICE USE ONLY:

Reference # _____ Sent: (*date*) _____

iPHIS ☐ _____

Contact Investigator _____

January 21, 2015 (eDOCS # 5396032 v3)

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 ON L4K 0G5, (905) 830-4444 extension 73065.