Notification of New Active or Reactivated Tuberculosis Case

Please return the completed form via fax and/or mail

York Region Community and Health Services – TB Program
9060 Jane Street, 5th Floor, Vaughan, ON L4K 0H5

Fax: 905-895-5450, 1-844-209-4389
Phone: 1-877-464-9675 ext.76000

If there are any questions, please contact the York Region Tuberculosis Control Program.

A PATIENT IDENTIFICATION

Last Name	First Name	Sex ☐ Male ☐ Female	Birth Date

Street Address	City	Postal Code	Health Card Number

Home Phone	Work Phone	Other Phone	Country of Birth	Date of Arrival

Marital Status	Language(s) Spoken	Occupation
☐ Single ☐ Married ☐ Common Law ☐ Separated ☐ Widowed	☐ English ☐ French ☐ Other(s) _____	

B MEDICAL HISTORY AND DIAGNOSTIC INFORMATION

Hospital Admission ☐ Yes ☐ No	Name of Hospital	Admission Date	Discharge Date

History of Tuberculosis	If reactivated case, specify first active episode
☐ New case ☐ Reactivated case	Year _____ Country _____

Symptoms	Onset date

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

Method of Detection
☐ Symptoms ☐ Contact ☐ Routine ☐ Immigration Medical Surveillance ☐ Other _____

Respiratory ☐ Pulmonary ☐ Laryngeal ☐ Other _____	Client's Level of Infectivity ☐ Low ☐ High

Non-Respiratory
☐ Miliary (disseminated) ☐ Extra Pulmonary (specify site) _____

Tuberculin Test Result

Mantoux (specify induration diameter result) _____ mm	Date Read

York Region Public Health
Phone: 1-877-464-9675 ext. 76000
Fax: 905-895-5450, 1-844-209-4389
york.ca/TB

York Region

Laboratory Status

	Microscopy			PCR			Culture		
	Sputum	BAL	Other	Sputum	BAL	Other	Sputum	BAL	Other
Negative	☐	☐		☐	☐		☐	☐	
Positive	☐	☐		☐	☐		☐	☐	

HIV Test

HIV Test Ordered?
☐ Yes ☐ No ☐ Refused

If HIV test is ordered
Result_____ Date_____

Chest Radiology Results (Please attach ALL radiology reports done within last 3 months)

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

Date of Test

C TREATMENT AND MORTALITY

Present Drug Regime

☐ ISONIAZID_____ mg ☐ RIFAMPIN_____ mg

Date Started

☐ PYRAZINAMIDE _____ mg ☐ PYRIDOXINE(B6) _____ mg ☐ OTHER _____ mg

☐ ETHAMBUTOL _____ mg ☐ OTHER _____ mg ☐ OTHER _____ mg

Drug Resistance
☐ Yes ☐ No ☐ Unknown

Please specify the resistant drug(s)

Was this case discovered after death?
☐ Yes ☐ No

If yes, Cause of Death
☐ TB – Cause ☐ TB – Contributed ☐ TB – Incidental

If yes, Date of Death	If yes, Next of Kin Name	If yes, Next of Kin Phone

Family Physician

Name	Address of Family Physician	Phone

Referral to Infectious Disease Specialist

Name	Address of Referral	Phone

Treating Physician (Please print)

Name	Address of Treating Physician	Phone

Remarks (such as other health problems)

Physician Signature	Date

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 Program, 9060 Jane Street, 5th Floor, Vaughan, Ontario L4K 0G5, 1-877-464-9675 extension 76000.