York Region

Community and Health Services Department

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:	
☐Male Female Other	Birth date:	Country of birth:
Healthcard #:	Phone #:	
Address:	City:	Postal code:
Index case information:		

PHYSICIAN TO COMPLETE THE FOLLOWING

History

1. Any previous TST/IGRA results

Result: _____mm Date: _____

Result: _____IU/mL Date: _____

2. Patient's risk factors to develop TB disease

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

3. Has the patient lived/travelled for longer than three months to a TB-endemic country?

☐ Yes, Country: _____ Date: _____

☐ No

4. Has patient ever worked, volunteered or lived in:

☐ Shelter ☐ Nursing home ☐ Correctional facility

☐ Psychiatric institution ☐ Refugee camp

TB Skin Test/IGRA result

☐ TST (Date Planted): _____

Date Read: _____ Result: _____ mm

☐ IGRA (QFT): _____

Date: _____ Result_____ IU/mL

(If the TST or IGRA was previously, or is currently, positive, a chest X-ray is required.)

Chest X-Ray

(If a chest x-ray was done within the last six months, provide a copy of the radiology report.)

Date of chest x-Ray: _____

Result: ☐ Normal ☐ Not done ☐ Unknown

Abnormal— (☐ Cavitary ☐ Non-Cavitary ☐ Not specified)

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

Was sputum collected? Yes No

Results: _____ Date: _____

Symptoms:

Was a referral made for further investigation?

☐ Yes, Name: _____ Phone: _____

☐ No

LTBI Treatment

Active TB must be ruled out before starting LTBI treatment.

Is active TB ruled out? ☐ Yes _ No

Was LTBI treatment initiated? Yes No

Prescription provided to patient: ☐ Yes ☐ No

Prescription faxed to one of the four pharmacies listed on the bottom of this form: ☐ Yes (fill in below) ☐ No

☐ Isoniazid_____mg ☐ Rifapentine(3HP) _____mg

☐ Rifampin_____mg ☐Pyridoxine(B6) _____mg

☐ Other_____mg

Proposed length of treatment:

☐ 3 months ☐ 4 months ☐ 6 months ☐ 9 months

☐ other: _____

York Region has four pharmacies that dispense free TB medication. ONLY send patients to one of the following:

- Guardian at Southlake (Southlake Regional Health Centre) 905-830-5988 Fax: 905-830-5984
- Dales Pharmacy (Markham-Stouffville Hospital) 905-471-1234 Fax: 905-471-3732
- Pure Health Pharmacy (Cortellucci Vaughan Hospital) 365-922-3200 Fax: 1-855-748-0796
- Pure Health Pharmacy (Mackenzie Health Richmond Hill) 905-883-7500 Fax: 905-883-7502

Physician's name/stamp:_____ **Date:**_____ **Physician's signature:**_____

TB Office use only

☐ 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, (905) 830-4444 extension 73065.