Appendix D – TB Forms and Client Letters

Note: this appendix contains low-resolution copies of the forms for your reference. Do not use these copies for client follow up, but please download the high resolution versions from SharePoint or wherever they are stored at your site.

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Active TB DOT Record

NUNATSIAVUT Health and Social Development | Labrador-Grenfell Health

Record of DOT Providers		
Initials	Name	Designation

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) _____ (yyyy)
MCP #: _____
Community: _____

ACTIVE TB DOT RECORD – INITIAL PHASE OF TREATMENT

Diagnosis:	Date of Diagnosis:	Treatment Start Date:	Known Drug Allergies:

PART 1: PRESCRIPTION – DO NOT ADJUST TREATMENT WITHOUT CONSULTING THE CDCN

☐ DOT _____ days per week x _____ doses ☐ Other (specify):

Drug	Dose (mg)	Date Started	Date Stopped	Drug	Dose (mg)	Date Started	Date Stopped
Isoniazid (INH)				Ethambutol			
Vitamin B6 (pyridoxine)							
Rifampin							
Pyrazinamide (PZA)							

PART 2: DIRECTLY OBSERVED THERAPY (DOT) – ALL DOSES MUST BE DOT

Before every dose: do symptom inquiry* and ask about possibility of travel or pregnancy. **Consult the CDCN** BEFORE ADMINISTERING DOSE if any adverse effects, abnormal blood test results, or the client becomes pregnant. **Consult the CDCN** to facilitate continuation of treatment during travel or when three doses in a row are missed and/or if adherence falls below 80% in a calendar month. **At month end**: calculate adherence†, complete required monitoring (see **Part 3**) and send **ATB-1** to the CDCN, along with updated growth chart for clients under five years of age.

MONTH (specify)	DAY OF THE MONTH Mark dates of observed doses with your initials. Mark dated of missed doses with an "O".																															Adherence‡			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	This Month		To Date	
																																DOT	DUE	DOT	DUE

PART 3: MONITORING – Clients whose TB treatment is provided by a CHA must have a face-to-face assessment by a nurse, a nurse practitioner, or a physician AT LEAST WEEKLY

	Date	Weight ¤ (kg)	S.I.* (✓)	Blood Tests (date/list) *Refer to TB Manual for testing requirements*	Sputum Specimen(s) for TB Testing§ *Indicate smear / culture results*				PA and Lateral Chest X-Rays§ Physician order required to x-ray a pregnant client	Pregnant Y / N or N/A	Vision Testing *(when taking ethambutol)*	
											Left Eye	Right Eye
Baseline					X3							
End of Week 1					X1							
End of Week 2					X1							
End of Week 3					X1							
End of Week 4					X1							
End of Week 8					X3							

* Ask about TB signs/symptoms, signs/symptoms of hepatotoxicity (extreme fatigue, stomach upset, nausea/vomiting, dark urine, yellow sclera, abdominal pain), and any other adverse effects.
† To calculate adherence as a percentage: #DOT doses divided by #doses DUE x 100. Example: seven doses observed divided by nine doses DUE (i.e. two doses missed) = 78% adherence.
‡ **DOT** = #of doses that were observed, **DUE** = #of doses that should have been taken/observed according to the prescription.
¤ Confirm dosing remains at therapeutic level. Consult CDCN about failure to gain weight in a growing child or weight loss in an adult or adolescent case, and when dosage adjustment indicated.
§ **For AFB smear-positive respiratory cases:** test one specimen each week until AFB-smear negative and test one specimen each month until culture-negative. **Consult CDCN** about: culture-positive specimens; if AFB smears or cultures go from negative to positive; or if Week 8 sputum specimens are culture-positive.

Active TB DOT Record (ATB-1) V1.0 **Page 1 of 2**

NUNATSIAVUT Health and Social Development | Labrador-Grenfell Health

Record of DOT Providers		
Initials	Name	Designation

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) _____ (yyyy)
MCP #: _____
Community: _____

ACTIVE TB DOT RECORD – CONTINUATION PHASE OF TREATMENT

PART 4: PRESCRIPTION – DO NOT ADJUST TREATMENT WITHOUT CONSULTING THE CDCN

☐ DOT 3 days per week (Mon/Wed/Fri) x 54 DOSES ☐ Other (specify):

Drug	Dose (mg)	Date Started	Date Stopped	Drug	Dose (mg)	Date Started	Date Stopped
Isoniazid (INH)							
Vitamin B6 (pyridoxine)							
Rifampin							

PART 5: DIRECTLY OBSERVED THERAPY (DOT) – ALL DOSES MUST BE DOT

Before every dose: do symptom inquiry* and ask about possibility of travel or pregnancy. **Consult CDCN** BEFORE ADMINISTERING DOSE if adverse effects, abnormal blood test results, or client becomes pregnant. **Consult CDCN:** if TB signs/symptoms worsen or recur; to arrange continuation of treatment during travel; or when three doses in a row are missed and/or if adherence falls below 80% in a calendar month. **At month end**: calculate adherence†; complete required monitoring (see **Part 6**); send **ATB-1** to CDCN with updated growth chart for clients under five years of age.

MONTH (specify)	DAY OF THE MONTH Mark dates of observed doses with your initials. Mark dates of missed doses with an "O".																															Adherence‡			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	This Month		To Date	
																																DOT	DUE	DOT	DUE

PART 6: MONITORING – Clients whose TB treatment is provided by a CHA must have a face-to-face assessment by a nurse, a nurse practitioner, or a physician AT LEAST WEEKLY

	Date	Weight** (kg)	S.I.* ✓	Blood Tests (date/list) *See Appendix D*	Sputum Specimen(s) for TB Testing§ *Indicate smear / culture results*				PA and Lateral Chest X-Rays§ Physician order required to x-ray a pregnant client	Pregnant Y / N / N/A	Vision Testing *(when taking ethambutol)*	
											Left Eye	Right Eye
Month 3					PRN							
Month 4					PRN							
Month 5					PRN							
Month 6					X3							
Month 7					PRN							

* TB signs/symptoms, symptoms of hepatotoxicity (extreme fatigue, stomach upset, nausea/vomiting, dark urine, yellow sclera, abdominal pain), and other adverse effects.
† Confirm dosing remains at a therapeutic level. Consult CDCN about failure to gain weight in a growing child or weight loss in an adjustment indicated.
‡ **DOT** = #of doses that were observed, **DUE** = #of doses that should have been taken/observed according to the prescription.
§ **For respiratory cases:** repeat three sputum specimens each month until culture-negative. **Consult CDCN** if culture-positive. Collect three sputum specimens and repeat chest x-rays within 1 mo. of anticipated completion date (usually Month 6).

Active TB DOT Record (ATB-1) V1.0 **Page 2 of 2**

Active TB DOT Record – Extension of Treatment

NUNATSIAVUT Health and Social Development | Labrador-Grenfell Health

Record of DOT Providers		
Initials	Name	Designation

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) _____ (yyyy)
MCP #: _____
Community: _____

ACTIVE TB DOT RECORD – EXTENSION OF TREATMENT

Diagnosis:	Date of Diagnosis:	Treatment Start Date:	Known Drug Allergies:

PART 1: PRESCRIPTION – DO NOT ADJUST TREATMENT WITHOUT CONSULTING THE CDCN

☐ **DOT three days per week (Mon/Wed/Fri) x 39 DOSES** ☐ **Other (specify):**

Drug	Dose (mg)	Date Started	Date Stopped	Drug	Dose (mg)	Date Started	Date Stopped

PART 2: DIRECTLY OBSERVED THERAPY (DOT) – ALL DOSES MUST BE DOT

Before every dose: do symptom inquiry* and ask about possibility of travel or pregnancy. **Consult the CDCN BEFORE ADMINISTERING DOSE** if any adverse effects, abnormal blood test results, or the client becomes pregnant. **Consult the CDCN** to facilitate continuation of treatment during travel or when three doses in a row are missed and/or if adherence falls below 80% in a calendar month. **At month end**: calculate adherence†, complete required monitoring (see **Part 3**), and send **ATB-2** to CDCN, along with updated growth chart for clients under five years of age.

Month (specify)	DAY OF THE MONTH Mark dates of observed doses with your initials. Mark dates of missed doses with an "O".																													Adherence‡			
																														This Month		To Date	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	DOT	DUE	DOT	DUE

PART 3: MONITORING – Clients whose TB treatment is provided by a CHA must have a face-to-face assessment by a nurse, a nurse practitioner, or a physician **AT LEAST WEEKLY**

Specify Treatment Month #	Date	Weight Ω (kg)	S.I.* ✓	Blood Tests (date/list) *Refer to TB Manual for testing requirements*	Sputum Specimen(s) for TB Testing§ *Indicate smear / culture results*				PA and Lateral Chest X-Rays§ Physician order required to x-ray a pregnant client	Pregnant Y / N or N/A	Vision Testing *(when taking ethambutol)*	
											Left Eye	Right Eye
Month:					PRN							
Month:					PRN							
Month:					X3							
Month:					PRN							

* Ask about TB signs/symptoms, signs/symptoms of hepatotoxicity (extreme fatigue, stomach upset, nausea/vomiting, dark urine, yellow sclera, abdominal pain), and any other adverse effects.
† To calculate adherence as a percentage: # DOT doses divided by # doses DUE x 100. Example: seven doses observed divided by nine doses DUE (i.e. two doses missed) = 78% adherence.
‡ **DOT** = # of doses that were observed, **DUE** = # of doses that should have been taken/observed according to the prescription.
Ω Confirm dosing remains at therapeutic level. Consult CDCN about failure to gain weight in a growing child or weight loss in an adult or adolescent case, and when dosage adjustment indicated.
§ **For respiratory cases:** repeat three sputum specimens each month until culture-negative. **Consult CDCN** if culture-positive. Collect three sputum specimens and repeat chest x-rays within one month of anticipated completion date.
PRN - Consult the CDCN and send three sputum specimens for TB testing if the client has a cough (dry or productive) for three weeks or longer.

Active TB DOT Record - Extension of Treatment (ATB-2) V1.0 **Page 1 of 1**

Active TB Treatment Outcome Form

NUNATSIAVUT Health and Social Development

Labrador-Grenfell Health

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) ____(yyyy)
MCP #: _____
Community: _____

ACTIVE TB TREATMENT OUTCOME FORM

PART 1: TREATMENT AND ADHERENCE SUMMARY

Diagnosis: **Date of Diagnosis:** dd/mm/yy

BOX 1.1 – INITIAL PHASE **Start Date:** dd/mm/yy **End Date:** dd/mm/yy

Medication	Start Date	Frequency 7x/wk DOT or 5x/wk DOT	Number of DOT Doses Taken	Date Discontinued or Completed
	dd/mm/yy			dd/mm/yy
	dd/mm/yy			dd/mm/yy
	dd/mm/yy			dd/mm/yy
	dd/mm/yy			dd/mm/yy
	dd/mm/yy			dd/mm/yy

BOX 1.2 – CONTINUATION PHASE **Start Date:** dd/mm/yy **End Date:** dd/mm/yy

Medication	# Daily DOT Doses Taken	# 3x/wk DOT Doses Taken	Date Discontinued or Completed	Number of doses expected	Treatment completed? (circle)	Yes	No
			dd/mm/yy		Percentage of treatment completed (circle one)		
			dd/mm/yy				
			dd/mm/yy		≥ 80%	50-79%	< 50%	Not known
			dd/mm/yy				

Was treatment extended: ☐ No ☐ Yes **If yes, why:** _____
Drug resistance at treatment start: ☐ No ☐ Yes ☐ Unknown
Drug resistance developed during the treatment ☐ No ☐ Yes *(specify)*: _____
If drug resistance, check all drugs that apply: ☐ INH ☐ RMP ☐ PZA ☐ EMB ☐ Other *(specify)*: _____

PART 2: END OF TREATMENT EXAMINATIONS

PA and Lateral Chest X-Rays	
Date: dd/mm/yy	**Result:** ☐ **Normal** ☐ **Abnormal (specify):**

Sputum Specimen Testing											
Specimen #1 Collection Date	Result (circle) include count if AFB smear is positive (e.g., 2+ or few)			Specimen #2 Collection Date	Result (circle) include count if AFB smear is positive (e.g. 2+ or few)			Specimen #3 Collection Date	Result (circle) include count if AFB smear is positive (e.g. 2+ or few)		
dd/mm/yy	AFB Smear	NEG	POS ____	dd/mm/yy	AFB Smear	NEG	POS ____	dd/mm/yy	AFB Smear	NEG	POS ____
	Culture	NEG	POS		Culture	NEG	POS		Culture	NEG	POS

CHN/TB Nurse Name / Signature: _____ **Date:** ____dd/mm/yy____

PART 3: TREATMENT OUTCOME AND SURVEILLANCE RECOMMENDATION (TO BE COMPLETED BY CDCN)

☐ Cure – negative culture at completion of treatment (as defined by Public Health Agency of Canada)
☐ Treatment completed – without culture at the end of treatment
☐ Death before or during treatment, *specify date of death:* ___dd/mm/yy___
☐ TB was the cause of death ☐ TB contributed to death but was not the underlying cause ☐ TB did not contribute to death
☐ Transferred to other territory/province/country – outcome of treatment unknown
Specify date and new territory/province/country: _____
☐ Failure – confirmed or recurrent positive cultures after 4 or more months of treatment
☐ Treatment discontinued due to adverse event *(specify)*: _____
☐ Treatment ongoing
☐ Absconded *(lost to follow-up before completion of 80% of doses)*
☐ Unknown
☐ Other *(specify)*: _____

SURVEILLANCE RECOMMENDATION: *See Table 13.1 in the TB Manual for details.*
☐ Surveillance not required ☐ Transferred to *Surveillance Protocol*, first assessment due: ___dd/mm/yy___

CDCN Name / Signature: _____ **Date:** ____dd/mm/yy____

Active TB Treatment Outcome Form (ATB-3) – V1.0 **Page 1 of 1**

Consent/Refusal for LTBI Treatment & WPP

CONSENT/REFUSAL FOR

LATENT TUBERCULOSIS INFECTION (LTBI)

TREATMENT

& WINDOW PERIOD PROPHYLAXIS (WPP)

CONSENT

I understand the information provided regarding the Tuberculosis medications for Latent TB Infection (LTBI) and Window Period Prophylaxis (WPP). I understand the risks and benefits and **I WANT** to receive medications for LTBI/ WPP as recommended by the Medical Officer of Health and/or my physician.

_____ _____

Signature **Date** **Witness**

REFUSAL

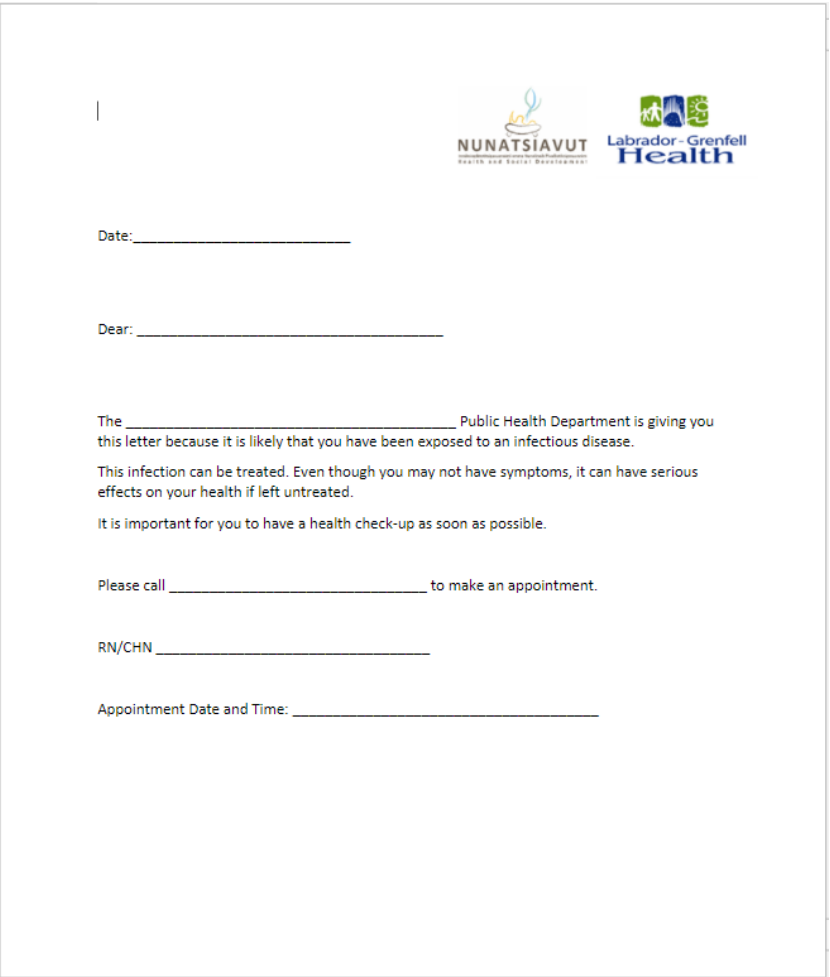
I understand the information provided regarding the Tuberculosis medications for Latent TB Infection (LTBI) and Window Period Prophylaxis (WPP). **I do not want** medications for LTBI as recommended by the Medical Officer of Health and/or my physician.

_____ _____

Signature **Date** **Witness**

* Please send the refusal or copy of refusal to Communicable Disease Control Nurse (CDCN), Labrador Health Centre, Goose Bay.

Contact Notification Letter



NUNATSIAVUT

Labrador-Grenfell Health

Date:_____

Dear: _____

The _____ Public Health Department is giving you this letter because it is likely that you have been exposed to an infectious disease.

This infection can be treated. Even though you may not have symptoms, it can have serious effects on your health if left untreated.

It is important for you to have a health check-up as soon as possible.

Please call _____ to make an appointment.

RN/CHN _____

Appointment Date and Time: _____

Latent TB Infection (LTBI) DOT Record

NUNATSIAVUT Health and Social Development

Labrador-Grenfell Health

Record of DOT Providers		
Initial	Name	Designation

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) ____(yyyy)
MCP #: _____
Community: _____

LATENT TB INFECTION (LTBI) DOT RECORD

Treatment Start Date:	Weight at Treatment Start: _____ kg	TB Contact (circle): YES NO	Known Drug Allergies:

PART 1: PRESCRIPTION – DO NOT ADJUST TREATMENT WITHOUT CONSULTING THE CDCN

☐ INH and Vitamin B6 DOT two days per week x 78 doses ☐ Rifampin DOT five days per week x 120 doses ☐ 3HP x 12 doses ☐ Other (specify):

Drug	Dose (mg)	Date Started	Date Stopped	Drug	Dose (mg)	Date Started	Date Stopped

PART 2: DIRECTLY OBSERVED THERAPY (DOT) – ALL DOSES MUST BE DOT

Before every dose: do symptom inquiry* and ask about possibility of travel or pregnancy. **Consult CDCN BEFORE ADMINISTERING DOSE** if adverse effects, abnormal blood test results, or client becomes pregnant. **Consult CDCN** to arrange continuation of treatment during travel, or when three doses in a row are missed and/or if adherence falls below 80% in a calendar month.

MONTH (specify)	DAY OF THE MONTH Mark dates of observed doses with your initials. Mark dates of missed doses with an "O".																													Adherence^			
																														This Month		To Date	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	DOT	DUE	DOT	DUE

At month end: calculate adherence**, complete required monitoring (see **Part 3**) and send the **LTBI-1** to CDCN, along with updated growth chart for clients under five years of age.
* Ask about TB signs/symptoms, signs/symptoms of hepatotoxicity (extreme fatigue, stomach upset, nausea/vomiting, dark urine, yellow sclera, abdominal pain), and any other adverse effects.
**To calculate adherence as a percentage: # DOT doses divided by # doses DUE x 100. Example: seven doses observed divided by nine doses DUE (i.e. two doses missed) = 78% adherence.
^ **DOT** = # of doses that were observed, **DUE** = # of doses that should have been taken/observed according to the prescription.

LTBI DOT Record (LTBI-1) – V1.0 **Page 1 of 2**

NUNATSIAVUT Health and Social Development

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) ____(yyyy)
MCP #: _____
Community: _____

LATENT TB INFECTION (LTBI) DOT RECORD

PART 3: MONITORING - Clients whose TB treatment is provided by a DOT must have a face-to-face assessment by a nurse, a nurse practitioner, or a physician **AT LEAST WEEKLY**.

Consult CDCN BEFORE ADMINISTERING DOSE if any adverse effects, abnormal blood test results, or the client becomes pregnant. Clients prescribed 78 twice-weekly doses of INH & Vitamin B6 must complete treatment within 12 months of start date. Clients prescribed120 daily doses of rifampin must complete treatment within six months of start date. Clients prescribed 3HP must complete a minimum of 11 doses within 16 weeks.

	Date	Weight* (kg)	S.I.^ Y/N	Specify Symptoms if Present (use abbreviations)	Blood Tests (date/list) *Refer to TB Manual for testing requirements*	Sputum Specimen(s) for TB Testing** *Indicate smear and culture results in spaces provided*				PA and Lateral Chest X-Rays (date/result)** Physician order required to x-ray a pregnant client	Pregnant Y/N or /N/A
End of Month 1						PRN					
End of Month 2						PRN					
End of Month 3						X3					
End of Month 4						PRN					
End of Month 5**						PRN					
End of Month 6						PRN					
End of Month 7						PRN					
End of Month 8**						PRN					
End of Month 9						PRN					
End of Month 10						PRN					
End of Month 11						PRN					
End of Month 12						PRN					

* Confirm dosing remains at a therapeutic level each month. **Notify the CDCN** about failure to gain weight in a growing child or weight loss in an adult or adolescent. **Consult the RCDC** when dosage adjustment is necessary.
^ TB signs/symptoms, symptoms of hepatotoxicity (extreme fatigue **(F)**, stomach upset **(SU)**, nausea/vomiting **(N/V)**, dark urine **(U)**, yellow sclera **(Y)**, abdominal pain **(AP)**, tingling hands/feet **(T)**, trouble seeing **(E)**, joint pain **(JP)**, rash/itching **(R/I)**, fever/chills/aches **(FV/C/A)** and any other adverse effects.
**Within one month of anticipated completion date, confirm with the CDCN whether end of treatment chest x-rays and/or sputum tests are required.
PRN - Consult the CDCN and send three sputum specimens for TB testing if the client has a cough (dry or productive) for three weeks or longer.

LTBI DOT Record (LTBI-1) – V1.0 **Page 2 of 2**

Latent TB Infection (LTBI) Treatment Outcome Form

NUNATSIAVUT Health and Social Development

Labrador-Grenfell Health

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) _____ (yyyy)
MCP #: _____
Community: _____

LATENT TB INFECTION (LTBI) TREATMENT OUTCOME FORM

PART 1: PURPOSE OF TREATMENT – SELECT ONE CATEGORY ONLY

- ☐ TB Contact – Window period prophylaxis (WPP)
- ☐ TB Contact – TST or IGRA positive at initial screening
- ☐ TB Contact – TST or IGRA positive at follow-up screening (i.e. converter)
- ☐ TB Contact – TST or IGRA negative, high risk for development of active TB if infected (e.g. immunosuppressed)
- ☐ TST or IGRA positive – no known recent TB contact (e.g., work screening, TB school screening)

PART 2: TREATMENT SUMMARY

Medication	Start Date	End Date	Number of DOT Doses Taken	Number of DOT Doses Prescribed
Isoniazid (INH)	dd/mm/yy	dd/mm/yy		
Vitamin B6 (pyridoxine)	dd/mm/yy	dd/mm/yy		
Rifampin (RMP)	dd/mm/yy	dd/mm/yy		
3 HP:	dd/mm/yy	dd/mm/yy		
Other:	dd/mm/yy	dd/mm/yy		

PART 3: ADHERENCE SUMMARY - %COMPLETED IS # OF DOT DOSES TAKEN DIVIDED BY # OF DOT DOSES PRESCRIBED x 100

Percentage of Treatment Completed: ☐ 100% ☐ 80 - 99% ☐ 50 - 79% ☐ < 50% ☐ Unknown

PART 4: RESULTS FROM MOST RECENT TB TESTING

If test not done, specify reason: _____

PA and Lateral Chest X-Rays	
Date: dd/mm/yy	**Result:** ☐ Normal ☐ Abnormal (specify):

Sputum Specimens for TB Testing											
Specimen #1 Collection Date	Result (circle) include count if AFB smear is positive (e.g. 2+ or few)			Specimen #2 Collection Date	Result (circle) include count if AFB smear is positive (e.g. 2+ or few)			Specimen #3 Collection Date	Result (circle) include count if AFB smear is positive (e.g. 2+ or few)		
dd/mm/yy	AFB Smear	NEG	POS ____	dd/mm/yy	AFB Smear	NEG	POS ____	dd/mm/yy	AFB Smear	NEG	POS ____
	Culture	NEG	POS ____		Culture	NEG	POS ____		Culture	NEG	POS ____

CHN/PHN/TB Nurse Name / Signature: _____ **Date:** ____dd/mm/yy_____

PART 5: TREATMENT OUTCOME AND SURVEILLANCE RECOMMENDATION (TO BE COMPLETED BY CDCN)

- ☐ Window period prophylaxis - treatment discontinued after repeat screening completed and **NEGATIVE**
- ☐ Treatment completed ☐ Death before completion of treatment, *specify date of death:* __dd/mm/yy__
- ☐ Transferred to other territory/province/country – outcome of treatment unknown
  Specify date and new territory/province/country: _____
- ☐ Treatment discontinued due to adverse event (*specify*): _____
- ☐ Treatment discontinued at request of client/parent/guardian) (*specify reason*): _____
- ☐ Absconded *(lost to follow-up before completion of 80% of doses)*
- ☐ Other (*specify*): _____

SURVEILLANCE RECOMMENDATION: *See Table 13.1 in the TB Manual for details.*
☐ Not required ☐ Transferred to ***Surveillance Protocol***, first assessment due: __dd/mm/yy____

CDCN Name / Signature: _____ **Date:** ____dd/mm/yy_____

LTBI Treatment Outcome Form (LTBI-2) – V1.0 **Page 1 of 1**

Medication Administration Consent – Day Care

Date: _____

To_____
(Name of Community Health Nurse)

Re: Administering TB Medication in Day Care

I give my permission for a healthcare worker from the Nunatsiavut Public Health Office or the Labrador Grenfell Regional Community Clinic in the community of _____ to administer TB medication to my child _____ on the Day Care premises until the date of _____

Sincerely

(Parent or Guardian to print name) _____

(Signature of Parent or Guardian) _____

Medication Administration Consent – School

Date: _____

To_____
(Name of Community Health Nurse)

Re: Administering TB Medication in School

I give my permission for a healthcare worker from the Nunatsiavut Public Health Office or the Labrador Grenfell Regional Community Clinic in the community of _____ to administer TB medication to my child _____ on the school premises until the date of _____

Sincerely

(Parent or Guardian to print name) _____

(Signature of Parent or Guardian) _____

Outpatient Specimen Collection Requisition

Newfoundland Labrador

Outpatient Specimen Collection Requisition

HCN:_ _ _ _ _ _ _ _ _ _ _ _ Type:_ _ _ Expiry: YYYY/MON/DD
First Name:_____ Surname:_____
DOB: YYYY/MON/DD Sex: ☐M ☐F ☐UN
Street Address:_____
P.O. Box:____ City:_____ Prov: _ _
Postal Code:_ _ _ _ _ _
Telephone: (Check Best) ☐Home (_ _ _) - _ _ _ - _ _ _ _
☐Cell (_ _ _) -_ _ _-_ _ _ _ ☐Work (_ _ _) - _ _ _ - _ _ _ _

Ordering Provider's Name:_____
Clinic Name:_____
Street Address:_____
_____
Phone: (_ _ _) -_ _ _- _ _ _ _
Fax: (_ _ _) -_ _ _- _ _ _ _
Ordering Provider's Meditech Mnemonic:_____
EMR Clinic Mnemonic:_____
Signature:_____ Date: YYYY/MON/DD

Clinic Stamp:(include fax, provider and mnemonics)

COPY TO PROVIDER _____

DIAGNOSIS / RELEVANT HISTORY
_____
_____
_____
_____

HEMATOLOGY

☐CBC..... (Includes automated differential)
☐PTI..... INR Anticoagulant_____

IMMUNOHEMATOLOGY

☐ BLTYABS.....Type and Screen

CHEMISTRY

☐ GLUFA..... Glucose (Fast 8hr)
☐ GLUCO..... Glucose – Random (Non-fasting)
☐ GTT2H..... 75 gm OGTT (Fast 8hr)
☐ G1HP50GGO.... 50 gm Prenatal Screen (Non-fasting)
☐ GTTG..... 75 gm OGTT (Fast 8hr; for PRE-NATAL use)
☐ HBA1CTHB..... Hemoglobin A1C
☐ CR..... Creatinine (with eGFR)
☐ SODIU..... Sodium
☐ POTAS..... Potassium
☐ BILTO..... Bilirubin, Total
☐ ALT..... Alanine Aminotransferase
☐ CALCI..... Calcium (with Albumin)
☐ URATE..... Uric Acid
☐ PROTE..... Total Protein
☐ ALBUM..... Albumin
☐ CREKI..... Creatine Kinase
☐ HEPFUP..... ALP, ALT (Reflex AST & Total Bilirubin)
☐ LIPIDP..... TChol, HDL, TG, Calculated LDL, non-HDLC
☐ TSH..... Thyroid Stimulating Hormone (Reflex fT4)
☐ CRPHS..... C-Reactive Protein
☐ FERRI..... Ferritin
☐ PSA.....Prostate Specific Antigen (PSA)

Frequency of Testing (For Repeat Testing)_____

THERAPEUTIC DRUG MONITORING

☐ Drug #1:
Date and Time of **Last** Dose: YYYY/MON/DD HH:MM
Date and Time of **Next** Dose: YYYY/MON/DD HH:MM

☐ Drug #2:
Date and Time of **Last** Dose: YYYY/MON/DD HH:MM
Date and Time of **Next** Dose: YYYY/MON/DD HH:MM

URINE TESTING **Antibiotics:** _____

☐ URINAP.....Urinalysis (reflex microscopic when applicable)
☐ HCGU.....Pregnancy Test
☐ URINCU.....Urine Culture ☐ Symptomatic ☐ Pregnant
(Urine cultures collected from indwelling catheters will be rejected)
☐ MALCRPU....Albumin/Creatinine Ratio (Microalbumin)

PRENATAL SCREENING

☐ BLTYABS ....Type and Screen
☐ PNS.....Prenatal Serology (Includes HIV, Rubella, HBSAG, Syphilis Screen)

MICROBIOLOGY

☐ HIVS.....HIV Screen ☐ HBSAB.....Hep B Immunity Screen
☐ TPALAB.....Syphilis Screen
☐ CTNGDP.....CT/NG Testing (Swab)
☐ CTNGDPU...CT/NG Testing (Urine)
☐ HEPDX.....Hepatitis Diagnosis Panel (HAV IgM, HBV surface Ag, anti-HBV core total, anti-HCV)

ADDITIONAL REQUESTS: **(MUST BE PRINTED LEGIBLY)**
_____
_____
_____
_____

If fasting is required – *do not eat anything* (except medications and/or water) for the time period indicated.
If you need additional information about preparing for your lab test, please contact your local Laboratory Medicine services.

Please note, some tests require an accompanying completed Special Authorization form before the test order can proceed.

**DATE & TIME OF COLLECTION:YYYY/MON/DD HH:MM INITIALS:_____*

Bar Code

Forms Control #

TB Case Interview Guide

TB Case Interview Guide

NB: This Guide is intended for use with a recently diagnosed case of TB, to help review their life and lifestyle during the time they may have been infectious and to identify contacts and persons who might need additional evaluation and assessment. All information obtained is confidential and client will be informed of same.

Name: *(add "usual name" or "also known as" for situations when client's usual name is different from birth certificate/MCP)*	
Date of Birth (DOB):	
MCP #:	
Address: **Other Address:** **Occupation:**	
Next of Kin (NOK): *(Name and telephone/contact details)*	
Have you ever had or been in contact with TB in the past? ○ If Yes, tell us about that. ○ When was that? ○ Have you spent time with someone who you know has had or is currently being treated for TB?	
○ Do you have diabetes? ○ Do you have problems with your kidneys? ○ Alcohol use? ○ Liver disease?	
Have you had any immunizations recently?	

○ If **Yes**, do you know what the immunizations were for? ○ Where were you when you had the immunizations?	
Determine Time Frame to ask about: *Note: The patient with smear-positive or symptomatic disease should be considered to have been infectious for **3 months** before onset of respiratory symptoms or the first positive finding consistent with TB, whichever is longer.* *Asymptomatic cases with a negative smear and no cavities seen on chest x-ray should be considered infectious **4 weeks** before the date that TB was suspected.* *For contact follow-up purposes, the period of infectiousness ends when the index case is in effective airborne isolation from others or is no longer infectious, whichever comes first.* *(Interviewer to use a calendar to help the patient remember).*	
When did you first notice symptoms of TB such as: ○ new or increased cough; ○ change in sputum; ○ weight loss; ○ fever; ○ night sweats?	Note the onset of the symptoms: month/year to present.
Ask questions to help identify where the person has spent time, and who s/he has spent time with while they were infectious:	
○ What type of work do you do? ○ Where do you work? ○ Who do you work with? ○ Do you work outside the community? ○ If yes, who do you work with there?	

○ Where do you stay overnight?
○ Who else stays/lives/sleeps there?
  ○ If Yes, how often, and for how long?
○ Do you couch surf?
  ○ If Yes, where and for how long?
○ Do you eat three meals per day?
  ○ Who prepares your meals?	

○ Who is your intimate sex partner? ○ Do you have more than one partner? ○ If yes, who are they? ○ Where do they live?	
○ Who else do you know who is sick and/or coughing? ○ Have any of your family or friends had a cough for more than three weeks? ○ Have any of your family or friends lost weight recently from sickness?	

○ Have any of your family or friends told you they have fever/night sweats?	

○ Where do you spend time?
○ Do you spend time at church?
  ○ If yes, can you tell me who attends regularly with you?
  ○ Are you in the choir?
○ Do you spend time at the recreation center?
○ Do you take part in regular sports activities?
○ If yes, who are your team members and coaches?
  - How often do you go and how long do you stay?	

○ Who do you spend time with? ○ Who do you spend the most time with each day? ○ Who do you spend the most time with each week?	
○ Who do you visit with?	
○ Do you smoke? ○ If yes, who do you smoke with?	
○ Do you drink? ○ If yes, who do you drink with?	

○ Do you smoke cannabis?
  ○ If yes, who do you smoke cannabis with?
  ○ If yes, do you use smoking devices such as bong, third lung, etc.?	

○ Did you travel outside your community?
  ○ Where did you stay?
  ○ How long did you stay?
  ○ Who else was there?
  ○ When did you travel?
  ○ When you were travelling and people visited, who did they bring with them?
  ○ Any children?
○ Have you had any visitors or spent time with visitors from outside your community?
○ Who do you camp/travel with?	

○ Have you spent any time in an institution, (e.g. Care home, group home, correctional center, rehab during the time of infectiousness)?
  ○ If yes, for how long?
  ○ If yes, did you share accommodations there?
  ○ If yes, who did you share with?	

○ Have you spent any time in college, university, or trade school over the past few months? ○ If yes, for how long?	

○ If yes, did you share accommodations there? ○ If yes, who did you share with? ○ Are there others outside your classmates that you hang out with inside or outside your school?	
○ Are any of your family and friends under five years of age?	
○ Which family and community gatherings have you attended? (Note: time frame inquiry should be within client period of infectiousness)	
○ Who in your family and friends has ever had TB? *(Asking this question can be helpful for identifying whether this case could be linked to another case).*	
Review the legend **'Type of contact'** listed below with the case, to determine if there are other people in the contact list who might have been missed.	
Type 1 - Household: people who slept in the same household as the case, such as: ○ Family; ○ Room-mates and boarders; ○ Overnight visitors; and ○ "Couch surfers".	
Type 2 - Close, Non-household: people who shared breathing space with the case daily, such as: ○ Caregivers; ○ Regular sexual partners;	

○ Close friends and extended family; ○ Daycare or primary/secondary school classroom contacts; and ○ Coworkers who work in close proximity, particularly in a small room.	
Type 3 – Casual (Non-household): people who spent time with the case less frequently than household or close non-household contacts, such as: ▯ High school classmates who share fewer courses with the case than Type 2 contacts; ○ Classmates in college/university classes; ○ Coworkers with less exposure than Type 2 contacts; ○ Members of a club, team, weekly children's playgroup or other social /recreational /religious group/choir/band; ○ Extended family members who are seen occasionally; and ○ Other students on a school bus.	
Thank you for your time and patience with this long interview process. Your answers will be very helpful to the TB investigation for you, your family and friends.	
Do you have any questions for Me? **(Provide the client with your contact information.)**	

Tuberculosis Assessment Form (TBAF)

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) ____(yyyy)
MCP #: _____
Community: _____

NUNATSIAVUT Health and Social Development | Labrador-Grenfell Health

NUNATSIAVUT TUBERCULOSIS ASSESSMENT FORM (TBAF)

PART 1: REASON FOR ASSESSMENT

☐ Employment or education requirement ☐ TB symptoms ☐ Client concern ☐ Health care provider referral
☐ Contact of TB case(s) — Date of last contact with case(s): YYYY / MON TB case(s) name & DOB: _____
☐ Other, describe _____
Initial: _____ **Date:** YYYY / MON / DD

PART 2: TB HISTORY

Prior Active TB: ☐ Y ☐ N **TB Type:** _____ → **Date:** YYYY / MON
Prior Active TB Treatment complete? ☐ Y ☐ N ☐ Unknown
Last TST Date: YYYY / MON / DD **Result:** _____(mm)
TST Recommended: ☐ Y ☐ N (If yes, see PART 6)
Last IGRA Date: YYYY / MON / DD **Result:** ☐ Positive ☐ Negative

Prior Latent TB: ☐ Y ☐ N → If Y, Date: YYYY / MON
Prior Latent TB treatment: ☐ Y ☐ N ☐ Unknown → If Y, ☐ Complete ☐ Not Complete ☐ Unknown

BCG Vaccination: ☐ Y ☐ N ☐ Unknown ☐ NA → If Y, year: _____
Past TB contact: ☐ Y ☐ N ☐ Unknown → If Y, Date of last contact: YYYY / MON

Initial: _____ **Date:** YYYY / MON / DD

PART 3: RISK FACTORS (CHECK ALL THAT APPLY)

☐ HIV Infection ☐ AIDS
☐ Incarceration at time of diagnosis
☐ Contact w/ infectious TB in the past 2y
☐ Abnormal CXR-fibronodular disease
☐ Abnormal CXR-granuloma
☐ TNF alpha inhibitors
☐ Diabetes mellitus (all types)
☐ Travel to high incidence TB country in past 2y

☐ Underweight (<90% ideal body weight / BMI<=20)
☐ Cigarette smoker (>1 pack/day)
☐ Cannabis smoker. (Describe freq in notes)
☐ Shares smoking devices (Describe freq in notes)
☐ Daily alcohol consumption (>3 drinks/day)
☐ Silicosis
☐ Hematologic malignancies (leukemia, lymphoma)
☐ Carcinoma of head and neck
☐ Homeless or inadequately housed

☐ Recent TB infection (TST conversion ≤ 2y ago)
☐ Other immunosuppressive drugs including corticosteroids
☐ Chronic renal failure requiring dialysis
☐ Young age when infected previously (0-4y)
☐ Organ transplantation requiring immune suppressant therapy
☐ Other, describe _____
☐ Denies all risk factors

TB Assessment Form (TBAF) V1.0 PAGE 1 of 5

NUNATSIAVUT TUBERCULOSIS ASSESSMENT FORM (TBAF)

NUNATSIAVUT Health and Social Development | Labrador-Grenfell Health

Name: _____
Date of Birth: YYYY / MON / DD Sex: ☐ M ☐ F ☐ UN

PART 4: TB SIGNS & SYMPTOMS ASSESSMENT

Cough: ☐ Y ☐ N Chest Pain: ☐ Y ☐ N Fever: ☐ Y ☐ N Fatigue: ☐ Y ☐ N Night Sweats: ☐ Y ☐ N
SOB : ☐ Y ☐ N Bloody sputum: ☐ Y ☐ N Pregnant: ☐ Y ☐ N Other Symptoms: ☐ Y ☐ N Denies all symptoms : ☐ Y ☐ N
Weight (kg): _____
Referred to Regional Community Clinic: ☐ Y ☐ N
Comments:
_____
_____

Initial: _____ **Date:** YYYY / MON / DD
Seen at Regional Community Clinic: ☐ Y ☐ N Initial: _____ **Date:** YYYY / MON / DD

PART 5: TUBERCULIN SKIN TESTING (IF RECOMMENDED)

Factsheet on TST provided: ☐ Y ☐ N Benefits & risks explained & understood: ☐ Y ☐ N Agree to return in 48-72 hrs: ☐ Y ☐ N
Client/Guardian signature: _____ **Date:** YYYY / MON / DD

Contraindications and Deferrals: Do Not Give TST if:

- Documented prior positive TST or IGRA
- Prior blistered TST reaction
- Previous active TB or LTBI
- Allergy to any component of PPD
- Previous anaphylactic reaction to PPD
- Current major viral infection (measles, mumps or varicella)- defer
- Live virus vaccine in the last four weeks: defer
- High dose steroids (equivalent to ≥ 15 mg prednisone daily for 2 to 4 weeks

Date given	Vaccine	Lot No.	Route	Site	Dose	Signature	Date read	Result (mm)	Signature

Initial TST Interpretation (see back of page 1) → Go to Part 7 to indicate follow-up recommendation
☐ Negative – no follow up required
☐ Negative – TB contact: repeat at least 8 weeks after break in contact.
Recall date: YYYY / MON / DD
☐ Negative – requires two step TST. Recall date: YYYY / MON / DD
☐ Negative – requires WPP & repeat TST. Recall date: YYYY / MON / DD
☐ Positive – proceed with clinical investigations

Final TST Interpretation
☐ Negative – no follow up required
☐ Positive – proceed with clinical investigations
☐ Lost to follow up
Initial: _____
Date: YYYY / MON / DD

TB Assessment Form (TBAF) V1.0 PAGE 2 of 5

NUNATSIAVUT TUBERCULOSIS ASSESSMENT FORM (TBAF)

NUNATSIAVUT Health and Social Development | Labrador-Grenfell Health

Name: _____

Date of Birth: YYYY / MON / DD Sex: ☐ M ☐ F ☐ UN

PART 6: FOLLOW-UP RECOMMENDED

CXR ordered: ☐ Y ☐ N → **Date:** YYYY / MON / DD **CXR completed:** ☐ Y → **Date:** YYYY / MON / DD

CXR Result: Normal ☐ Abnormal ☐ **Date:** YYYY / MON / DD **Initial:** ____

Normal ☐ Abnormal ☐ **Date:** YYYY / MON / DD **Initial:** ____

Attach any abnormal chest x-ray report.

Sputum specimens x 3 ordered: ☐ Y ☐ N → **Date:** / MON / **Initial:** ____

Sputum specimen	Smear	Culture	PCR	Initials
Specimen #1	☐ Positive: *Circle growth:* +1 +2 +3 +4 ☐ Negative ☐ Not done ☐ Unknown	☐ Positive: *# days to growth:* ☐ Negative ☐ Not done ☐ Unknown		
Specimen #2	☐ Positive: *Circle growth:* +1 +2 +3 +4 ☐ Negative ☐ Not done ☐ Unknown	☐ Positive: *# days to growth:* ☐ Negative ☐ Not done ☐ Unknown		
Specimen #3	☐ Positive: *Circle growth:* +1 +2 +3 +4 ☐ Negative ☐ Not done ☐ Unknown	☐ Positive: *# days to growth:* ☐ Negative ☐ Not done ☐ Unknown		

Other specimen culture and results:

Date: YYYY / MON / DD **Initial:** ____

Referred to TB clinic: ☐ Y ☐ N → **If Y, date:** YYYY / MON / DD **Attended TB clinic:** ☐ Y → **Date:** YYYY / MON / DD

Sputum induction ordered: ☐ Y ☐ N → **If Y, date:** YYYY / MON / DD **Induction completed:** ☐ Y → **Date:** YYYY / MON / DD

PART 7: DIAGNOSTIC & OUTCOME SUMMARY TO BE FILLED OUT **ONLY** WHEN INITIAL ASSESSMENT IS COMPLETE

Diagnostic summary:

Client result:	Diagnostic finding:
☐ Y ☐ N ☐ Not done	TB signs/symptoms present
☐ Y ☐ N ☐ Not done	TST or IGRA positive
☐ Y ☐ N ☐ Not done	Abnormal chest X-ray (TB-related)
☐ Y ☐ N ☐ Not done	Sputum smear positive for TB
☐ Y ☐ N ☐ Not done	Sputum culture positive for TB
☐ Y ☐ N ☐ Not done	Other culture positive
☐ Y ☐ N ☐ Not done	Other: _____

Outcome and next steps:

- ☐ **Active TB diagnosis**: Type:
  Proceed with treatment, using *Active TB DOT Record*
- ☐ **LTBI diagnosis**: Eligible for treatment: ☐ Y ☐ N
  Offered treatment: ☐ Y ☐ N
  Accepted treatment: ☐ Y ☐ N
  - *Use Latent TB DOT Record*
- ☐ **Under 5 on WPP**: Proceed with *Latent TB DOT Record*
- ☐ **High risk, on surveillance**: Use *TB Surveillance and Outcome form*
- ☐ Discharged- no further follow up required
- ☐ Lost to follow-up (including died)
- ☐ Refused assessment
- ☐ Unable to establish contact with client
- ☐ Other (please specify): _____

Initial: _____ **Date:** YYYY / MON / DD

TB Assessment Form (TBAF) V1.0 **PAGE 3 of 5**

NUNATSIAVUT TUBERCULOSIS ASSESSMENT FORM (TBAF)

NUNATSIAVUT Health and Social Development | Labrador-Grenfell Health

Name: _____

Date of Birth: YYYY / MON / DD Sex: ☐ M ☐ F ☐ UN

SIGNATURE MASTER LIST

Date	Print Name	Signature	Initial	Designation

TB Assessment Form (TBAF) V1.0 **PAGE 4 of 5**

Tuberculosis Assessment Form (TBAF) Continued

NUNATSIAVUT TUBERCULOSIS ASSESSMENT FORM (TBAF)

NUNATSIAVUT Health and Social Development | Labrador-Grenfell Health

Name: _____

Date of Birth: YYYY / MON / DD Sex: ☐ M ☐ F ☐ UN

PROGRESS NOTES

Date	Progress Notes

TB Assessment Form (TBAF) V1.0 **PAGE 5 of 5**

Tuberculosis Investigation Record

TUBERCULOSIS INVESTIGATION RECORD

UPDATED: _____ dd/mm/yy _____

NUNATSIAVUT Health and Social Development — Labrador-Grenfell Health

TB Contact Investigation: Use the **TB Contact Testing Flowchart.** Contacts with prior active TB or LTBI (treated or untreated), and contacts diagnosed with active TB or LTBI during the first round of testing do not require a second round of testing unless they present with TB signs/symptoms. A TST result of equal to or greater than 5 mm of induration is considered "positive".
Source Case Investigation: Use the **General TB Testing Flowchart**. Do a single round of screening only.

Case Name (Last, First)				DOB (dd/mm/yy)	Community		Diagnosed (dd/mm/yy)				Type of TB	Status at Time of Diagnosis (✓ all that apply) ☐ AFB Smear-positive: + _____ (include count if AFB smear is positive) ☐ Culture pending ☐ AFB Smear-negative ☐ Cavitary TB on chest X-ray ☐ Culture-positive ☐ Culture-negative							
#	Contact Name (Last, First)	DOB & Age	TB related history	Date of Last Exposure & MCP #	Comm/ Sex	Contact Type* & Relationship to Case	S/S**	Last Prior TST Date & Result (mm)	Post Exposure TSTs	Test Date	Result	Chest X-Ray Date & Result‡		Sputum Report Dates & Results◆					Current Status
		dd/mm/yy		dd/mm/yy				dd/mm/yy	TST 1	dd/mm/yy	mm	dd/mm/yy		dd/mm/yy		dd/mm/yy		dd/mm/yy	☐ _____
								mm	TST 2	dd/mm/yy	mm			S	C	S	C	S	C	☐ Closed ☐ Lost to Follow-up
		dd/mm/yy		dd/mm/yy				dd/mm/yy	TST 1	dd/mm/yy	mm	dd/mm/yy		dd/mm/yy		dd/mm/yy		dd/mm/yy	☐ _____
								mm	TST 2	dd/mm/yy	mm			S	C	S	C	S	C	☐ Closed ☐ Lost to Follow-up
		dd/mm/yy		dd/mm/yy				dd/mm/yy	TST 1	dd/mm/yy	mm	dd/mm/yy		dd/mm/yy		dd/mm/yy		dd/mm/yy	☐ _____
								mm	TST 2	dd/mm/yy	mm			S	C	S	C	S	C	☐ Closed ☐ Lost to Follow-up
		dd/mm/yy		dd/mm/yy				dd/mm/yy	TST 1	dd/mm/yy	mm	dd/mm/yy		dd/mm/yy		dd/mm/yy		dd/mm/yy	☐ _____
								mm	TST 2	dd/mm/yy	mm			S	C	S	C	S	C	☐ Closed ☐ Lost to Follow-up
		dd/mm/yy		dd/mm/yy				dd/mm/yy	TST 1	dd/mm/yy	mm	dd/mm/yy		dd/mm/yy		dd/mm/yy		dd/mm/yy	☐ _____
								mm	TST 2	dd/mm/yy	mm			S	C	S	C	S	C	☐ Closed ☐ Lost to Follow-up
		dd/mm/yy		dd/mm/yy				dd/mm/yy	TST 1	dd/mm/yy	mm	dd/mm/yy		dd/mm/yy		dd/mm/yy		dd/mm/yy	☐ _____
								mm	TST 2	dd/mm/yy	mm			S	C	S	C	S	C	☐ Closed ☐ Lost to Follow-up
		dd/mm/yy		dd/mm/yy				dd/mm/yy	TST 1	dd/mm/yy	mm	dd/mm/yy		dd/mm/yy		dd/mm/yy		dd/mm/yy	☐ _____
								mm	TST 2	dd/mm/yy	mm			S	C	S	C	S	C	☐ Closed ☐ Lost to Follow-up

NOTE: Chest x-rays taken within the prior month may be used in place of taking new x-rays provided the contact is asymptomatic **AND** the results were reported as "normal". A physician order is required to x-ray a pregnant client.

***Type 1 - HOUSEHOLD**: Slept in the same household as the case, e.g.: family, room-mates, boarders, "couch surfers", overnight visitors. **Type 2 - CLOSE NON-HOUSEHOLD**: Shared breathing space with the case daily, e.g.: caregivers, regular sexual partners, close friends, extended family, daycare, primary/secondary school classroom contacts, coworkers who work in close proximity, particularly in small rooms. **Type 3- CASUAL/COMMUNITY**: Spent time with the case less frequently than household or close non-household contacts, e.g.: high school classmates who share fewer courses with the case, classmates in college/university classes, less exposed colleagues at work, members of a club, team, weekly children's playgroup or other social/recreational/religious group, extended family members who are seen occasionally, other students on a school bus.

****Signs/Symptoms**: Cough = C, Fever = F, Night sweats = NS, Weight Loss = WL, Other = O ‡**Chest X-Ray Results**: Normal = N, Abnormal = ABN ◆**Sputum Results**: AFB Smear-Negative = S-, AFB Smear-Positive = S+, Culture-Negative = C- , Culture-Positive = C+

TB Investigation Record (TB-IR) V1.0

Page 1 of _____

Tuberculosis Surveillance and Outcome Form

NUNATSIAVUT Health and Social Development

Labrador-Grenfell Health

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) ____(yyyy)
MCP #: _____
Community: _____

TUBERCULOSIS SURVEILLANCE AND OUTCOME FORM

REPORT ALL ABNORMAL RESULTS TO CDCN *Surveillance schedule as per table 13.1 in TB Manual*

Screening DUE dd/mm/yy Weight: _____ kg	Cough	☐ No	☐ Yes x ___ wks	Chest pain	☐ No	☐ Yes x ___ wks	Fatigue	☐ No	☐ Yes x ___ wks			
	Fever	☐ No	☐ Yes x ___ wks	Night sweats	☐ No	☐ Yes x ___ wks	Short of breath	☐ No	☐ Yes x ___ wks			
	Sputum	☐ No	☐ Yes x ___ wks	Blood in Sputum	☐ No	☐ Yes x ___ wks	Weight loss	☐ No	☐ Yes x ___ kgs			
	Other (specify) :					x ___ wks			since: (mm/yy)			
	Chest X-Ray*		Sputum #1*		Sputum #2*		Sputum #3*					
	dd/mm/yy	result	dd/mm/yy	result	dd/mm/yy	result	dd/mm/yy	result				
DONE dd/mm/yy	Comments:											
	CHN/PHN Name/Signature: _____ Date: dd/mm/yy											
Screening DUE dd/mm/yy Weight: _____ kg	Cough	☐ No	☐ Yes x ___ wks	Chest pain	☐ No	☐ Yes x ___ wks	Fatigue	☐ No	☐ Yes x ___ wks			
	Fever	☐ No	☐ Yes x ___ wks	Night sweats	☐ No	☐ Yes x ___ wks	Short of breath	☐ No	☐ Yes x ___ wks			
	Sputum	☐ No	☐ Yes x ___ wks	Blood in Sputum	☐ No	☐ Yes x ___ wks	Weight loss	☐ No	☐ Yes x ___ kgs			
	Other (specify) :					x ___ wks			since: (mm/yy)			
	Chest X-Ray*		Sputum #1*		Sputum #2*		Sputum #3*					
	dd/mm/yy	result	dd/mm/yy	result	dd/mm/yy	result	dd/mm/yy	result				
DONE dd/mm/yy	Comments:											
	CHN/PHN Name/Signature: _____ Date: dd/mm/yy											
Screening DUE dd/mm/yy Weight: _____ kg	Cough	☐ No	☐ Yes x ___ wks	Chest pain	☐ No	☐ Yes x ___ wks	Fatigue	☐ No	☐ Yes x ___ wks			
	Fever	☐ No	☐ Yes x ___ wks	Night sweats	☐ No	☐ Yes x ___ wks	Short of breath	☐ No	☐ Yes x ___ wks			
	Sputum	☐ No	☐ Yes x ___ wks	Blood in Sputum	☐ No	☐ Yes x ___ wks	Weight loss	☐ No	☐ Yes x ___ kgs			
	Other (specify) :					x ___ wks			since: (mm/yy)			
	Chest X-Ray*		Sputum #1*		Sputum #2*		Sputum #3*					
	dd/mm/yy	result	dd/mm/yy	result	dd/mm/yy	result	dd/mm/yy	result				
DONE dd/mm/yy	Comments:											
	CHN/PHN Name/Signature: _____ Date: dd/mm/yy											
Screening DUE dd/mm/yy Weight: _____ kg	Cough	☐ No	☐ Yes x ___ wks	Chest pain	☐ No	☐ Yes x ___ wks	Fatigue	☐ No	☐ Yes x ___ wks			
	Fever	☐ No	☐ Yes x ___ wks	Night sweats	☐ No	☐ Yes x ___ wks	Short of breath	☐ No	☐ Yes x ___ wks			
	Sputum	☐ No	☐ Yes x ___ wks	Blood in Sputum	☐ No	☐ Yes x ___ wks	Weight loss	☐ No	☐ Yes x ___ kgs			
	Other (specify) :					x ___ wks			since: (mm/yy)			
	Chest X-Ray*		Sputum #1*		Sputum #2*		Sputum #3*					
	dd/mm/yy	result	dd/mm/yy	result	dd/mm/yy	result	dd/mm/yy	result				
DONE dd/mm/yy	Comments:											
	CHN/PHN Name/Signature: _____ Date: dd/mm/yy											

‡ Results: Normal = N, Abnormal = ABN *Results: AFB Smear Neg = SM - AFB Smear Pos = SM + Culture Neg = C - Culture Pos = C+

SURVEILLANCE OUTCOME – complete at end of surveillance period and then email or fax to CDCN		
☐ Discharged - surveillance completed	☐ Lost to follow-up	☐ Active TB - date of diagnosis: dd/mm/yy
☐ Transferred out of region prior to end of surveillance period – outcome of surveillance unknown		Date of transfer: dd/mm/yy
Location where client transferred to:		
☐ Died prior to end of surveillance period (*specify date*): dd/mm/yy	Other (specify):	
CHN/PHN Signature:		Date: dd/mm/yy

TB Surveillance and Outcome Form (TB Surv) – V1.0

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Tuberculosis Travel/Transfer Form

NUNATSIAVUT Health and Social Development

Labrador-Grenfell Health

Last Name: _____
First Name: _____
Sex: ☐ M ☐ F ☐ Other: _____
Date of Birth: ___ (dd) ___ (mm) ____(yyyy)
MCP #: _____
Community: _____

TUBERCULOSIS TRAVEL / TRANSFER FORM

PART 1: TRAVEL DETAILS ADVISE CLIENT WHERE TO REPORT WITH HIS/HER MEDICATIONS FOR DIRECTLY OBSERVED THERAPY

Traveling to: _____
House #: _____
Boarding home: _____
Hotel/Other: _____
Contact Person: _____
Phone: _____

Departure date: _____dd/mm/yy _____
Reason for travel (e.g., medical / pleasure / work):
_____
Traveling companion(s): _____
Expected length of trip: _____
Expected date of return: _____dd/mm/yy_____ _ ___

PART 2: CLINICAL INFORMATION

Treatment for Active TB				
Active TB Disease *(specify type)* _____ TB Drug Resistance ☐ No ☐ Yes ☐ Unknown	Date of Diagnosis	Treatment Start	Current Sputum AFB Smear Status include count if AFB smear is positive (e.g. 2+ or few)	Current Sputum TB Culture Status (circle one)
	dd/mm/yy	dd/mm/yy	Collection Date: dd/mm/yy Result (*circle*): Positive _____ Negative	Collection Date: dd/mm/yy Result (*circle*): Positive Negative Pending

Window Period Prophylaxis					
Window Period Prophylaxis	Treatment Start	Dates/Results of Initial Post-Exposure Tests			Date Repeat Tests Due
	dd/mm/yy	TST	dd/mm/yy	_____ mm	dd/mm/yy
		Chest X-Ray	dd/mm/yy	result	dd/mm/yy

Treatment for Latent TB Infection			
Latent TB Infection	Treatment Start	Estimated Completion Date	Doses Left to Complete
	dd/mm/yy	dd/mm/yy	

PART 3: TREATMENT INFORMATION

Medications with client: ☐ No ☐ Yes If yes, number of doses provided: _____ Blister packed? ☐ No ☐ Yes
Last dose observed: _____dd/mm/yy_____ Next observed dose due: _____dd/mm/yy___ _____

PART 4: MONITORING INFORMATION

Date of most recent blood tests: ____dd/mm/yy___ Next blood tests due (*specify*): _____ Date due: ___dd/mm/yy_ _
Other monitoring due (*specify with dates due*): _____

PART 5: ATTACHED INFORMATION

☐ Copy of most recent sputum test results (for client with respiratory TB) ☐ Copy of most recent blood test results if abnormal
☐ DOT record ☐ Other (*specify*):

PART 6: COMMENTS

For travel within same region: send to CHN of destination community. For travel outside of region/ province: send to CDCN.

CHN/PHN Name & Signature: _____ Date: __dd/mm/yy___ Phone: _____

TB Travel/Transfer Form (TB Trans) – V1.0 Zoom **Page 1 of 1**