



Adults with a Significant Tuberculin Skin Test Referral

Client Health Record #

Client Surname

Given Name

Date of Birth

Gender

MFRN

PHIN

Address

Choose appropriate clinic and send referral via fax:

- Clinic (204-784-4013)
- Access Downtown (204-942-7828)
- Access Fort Garry (204-940-7090)
- Other: _____

Client Alternate Identification:	Type:	Client Primary Phone
Client Primary Language:		Client Alternate Phone
If primary language is not English, does client speak and understand English? <input type="checkbox"/> Yes <input type="checkbox"/> No		

TST Testing: _____ mm induration on <table border="1" style="display: inline-table; text-align: center; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table> , Step one _____ mm induration on <table border="1" style="display: inline-table; text-align: center; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table> , Step two, if applicable																						D	D	M	M	M	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y																						D	D	M	M	M	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	TST(s) performed by:
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Chest X-ray (PA within previous 5 months; PA & lateral if HIV positive)

Report included with fax

Reason for TST:

Suspected contact of a case of TB (do NOT refer to Primary Care, see footnote below)

Suspected case of active TB disease (do NOT refer to Primary Care, see footnote below)

Refugee/immigrant from TB-endemic country
 Countries (list all, with dates): _____
 Date of arrival in Canada:

D	D	M	M	M	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

 Is client under TB medical surveillance? Yes No

Immunocompromised, or high-risk medical condition
 Details: _____

Occupational screening (school, workplace, etc.)
 Details: _____

Traveller, details: _____

Other reason: _____

Previous TB History: List all details:

Yes No Don't know Previous diagnosis or treatment of TB disease or infection

Yes No Don't know Previous BCG vaccination (list age)

Current & Past Medical, Surgical History:

Other Information:

Referring Clinician	Date <table border="1" style="display: inline-table; text-align: center; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>																						D	D	M	M	M	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Phone
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Address	City/Town	Postal Code	Fax																																									

Your client will be notified within 5 business days regarding an appointment.

Note: Clients with Suspected Active TB Disease, Pediatric Clients, and Contacts of Active Cases
 Primary Care clinics are not assessing clients with suspected active TB disease, any pediatric clients or TB contacts referred from the community. All adults suspected of active TB disease should be referred to the Health Sciences Centre Adult Respiratory Outpatient Department immediately (tel. 204-787-2384, fax 204-787-2420) or the local Adult Emergency Department (notify Emergency prior to sending the client). Children suspected of active TB disease should be referred immediately to Children's Emergency, or to the Children's Hospital Outpatient Department (tel. 204-789-3619, fax 204-787-4503). Children with a significant TST can be referred to the Children's Outpatient Department. Report adults and children suspected of being in contact with an active case of TB to the Manitoba Tuberculosis Control Program, (tel. 204-945-4816, fax 204-948-3775). Remember, the TST cannot be used to reliably test for active tuberculosis disease.