

# Reporting Latent TB Infection (LTBI) and TB Drug Order

**Please note: The following is required to process initial drug orders:**  
 1. TB Skin Test date and result in mm of induration or positive IGRA result  
 2. Copy of the chest x-ray report done within the last three months

**Reporting LTBI**

**Ordering TB Drugs**

Patient's Last Name	First Name	Initial	Date of Birth	Yr.	Mo.	Day	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/> Transgender <input type="checkbox"/> Unknown			
Address			Telephone No. Home: _____ Bus: _____							
City	Postal Code		Country of Birth		Date of Arrival in Canada			Yr.	Mo.	Day

<b>TB Skin Test</b> Date _____ Result _____ mm <b>TB Skin Test</b> Date _____ Result _____ mm  <b>History of BCG</b> <input type="checkbox"/> Yes (Approximate age given) _____ <input type="checkbox"/> No <b>Chest X-Ray</b> Date _____ <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal	<b>HIV Testing</b> Date _____ Result _____ <b>IGRA Testing</b> Date _____ Result _____  <b>Medical Risk Factors</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Diabetes <input type="checkbox"/> Renal Disease <input type="checkbox"/> Immunosuppressive therapy / disease <input type="checkbox"/> Other (specify): _____  <b>Sputum sent for AFB and culture</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Note:</b> Drug orders will not be processed if culture results or consult notes from Specialists are pending
<b>Reason for TB Skin Test</b> <input type="checkbox"/> Routine (includes volunteer, school, employment purposes) <input type="checkbox"/> Contact of a case <input type="checkbox"/> Symptoms (specify) _____  <b>Referral to a Specialist</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Name of specialist:</b> _____	

<b>LTBI Treatment:</b> <input type="checkbox"/> accepted <input type="checkbox"/> contraindicated <input type="checkbox"/> declined <b>LTBI Treatment (please circle length of treatment):</b> <input type="checkbox"/> RMP    600    mg po daily x    4    months <input type="checkbox"/> RMP    450    mg po daily x    4    months <input type="checkbox"/> Vitamin B6    25    mg po daily x    6    9    12    months <input type="checkbox"/> INH    300    mg po daily x    6    9    12    months <input type="checkbox"/> INH syrup    _____    mg po daily x    6    9    12    months <input type="checkbox"/> Other _____  Weight _____ kg Recommended INH dosage for children is 10-15 mg/kg up to 300mg max.	<b>Treatment Start Date</b> (YYYY/MM/DD) Initial Order    Date _____ 1 <sup>st</sup> Repeat    Date _____ 2 <sup>nd</sup> Repeat    Date _____ 3 <sup>rd</sup> Repeat    Date _____  <b>Treatment End Date</b> _____ (YYYY/MM/DD)  <b>Reason Treatment Ended</b> <input type="checkbox"/> Adequate Treatment <input type="checkbox"/> Non-adherent <input type="checkbox"/> Never returned <input type="checkbox"/> Side Effects <input type="checkbox"/> Other
<b>Patient Counsellor:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Signs and Symptoms of TB disease <input type="checkbox"/> Side effects of TB Medications	<input type="checkbox"/> When to seek medical attention <input type="checkbox"/> TB Pamphlets given

PLEASE <u>FAX</u> THE COMPLETED FORM AND COPY OF THE CHEST X-RAY REPORT TO: FAX: (905) 565-8428  Peel Public Health Communicable Disease Control Phone: (905) 791-7800 ext: 2796	<b>Physician Name:</b> _____ <b>Address</b> _____ <b>Phone No</b> _____ <b>Fax</b> _____  <b>Signature</b> _____
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