

Section C: TUBERCULOSIS (TB) QUESTIONNAIRE

To be completed **ONLY** by those who have recently or historically had a **POSITIVE TB SKIN TEST (TST)**

LHSC follows the Ontario Hospital Association (OHA) Tuberculosis Surveillance Protocol for all staff with a positive TB skin test. A positive TB Skin Test occurs following exposure to TB, during active TB, or as a result of BCG vaccination. The information you provide on this form will assist Occupational Health & Safety Services (OHSS) to determine the reason for your positive result, the need for further investigation, or the benefit of additional medical assessment. OHSS will provide additional health teaching resources, or schedule an appointment with the OHSS Nurse Practitioner.

Name:			Position:								
Employee ID #:											
Positive TB Skin Test			BCG Vaccination								
<table><tr><td>Date Planted</td><td>Date Read</td><td>Level of Induration</td></tr><tr><td></td><td></td><td></td></tr></table>			Date Planted	Date Read	Level of Induration				Have you received BCG vaccination? Yes No		
Date Planted	Date Read	Level of Induration									
Test completed by: <input type="text"/>			Date(s): <input type="text"/>								
Location: <input type="text"/>			<input type="text"/>								
Chest X-Ray Have you ever had abnormal findings on a chest X-ray relating to TB?			< 2 years of age								
Yes			> 2 years of age								
Findings: <input type="text"/>			In What country did you receive this vaccination?								
No			<input type="text"/>								
History History of active TB disease			Immigration and Travel								
Yes			Country of Birth: <input type="text"/>								
No			Country from which you immigrated to Canada:								
Unprotected TB exposures in previous year			<input type="text"/>								
Yes			Date of Immigration to Canada:								
No			<input type="text"/>								
History of symptoms of active TB in previous year:			Age at Immigration: <input type="text"/>								
Yes			Have you travelled to any TB endemic countries??								
No			Yes								
If yes, what symptoms have you experienced?			Where: <input type="text"/>								
Productive Cough Unexplained Weight loss			No								
Loss of Appetite Fatigue											
Fever Cough up blood											
Chest Pain Night Sweats											

<div><div><div>Medical Follow Up</div><div>Have you consulted with a medical practitioner or Infectious Diseases Specialist about your positive TB Skin test?</div><div><div>Yes → Attach documentation if available</div><div>No</div></div><div>Have you had an IGRA test?</div><div><div>Yes</div><div>Result:</div><div>Negative</div><div>Positive</div></div><div>Date of Test: _____ → Attach result</div><div>No</div><div>Have you been treated for Latent TB Infection (LTBI)?</div><div><div>Yes</div><div>Medication: _____</div><div>Length of Treatment: _____</div><div>Date completed: _____</div></div><div>No</div></div></div> <div><div>IMPORTANT INFORMATION:</div><div>To prevent a significant reaction, you must avoid having additional TB Skin Tests</div><div>It is recommended that you maintain a personal record of your TB Skin Test and Chest X-Ray for future reference</div><div>Should you develop signs or symptoms of active TB you must seek out medical attention immediately.</div></div>	
<div>Signature:</div>	<div>Date:</div>