London Health Sciences Centre

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:

Employee ID #:

Position:

Positive TB Skin Test

Date Planted	Date Read	Level of Induration

Location where test was completed:

Chest X-Ray A Chest X-Ray is required **following** the date the TB skin test was read. Please **attach a copy** of the X-ray Report.

Date of Chest X-ray	**Result (Normal/Abnormal)**

Have you ever had abnormal findings on a chest X-ray relating to TB?

☐ **Yes**
Findings:

☐ **No:**

BCG Vaccination

Have you received BCG vaccination?

☐ Yes
☐ No

Date(s):

☐ < 2 years of age
☐ > 2 years of age

In What country did you receive this vaccination?

History

History of active TB disease
☐ Yes
☐ No

Unprotected TB exposures in previous year
☐ Yes
☐ No

History of symptoms of active TB in previous year:
☐ Yes
☐ No

If yes, what symptoms have you experienced?

☐ Productive Cough ☐ Unexplained Weight loss
☐ Loss of Appetite ☐ Fatigue
☐ Fever ☐ Cough up blood
☐ Chest Pain ☐ Night Sweats

Immigration and Travel

Country of Birth:

Country from which you immigrated to Canada:

Date of Immigration to Canada:

Age at Immigration:

Have you travelled to any TB endemic countries?

☐ Yes Where:
☐ No:

Medical Follow Up

Have you consulted with a medical practitioner or Infectious Diseases Specialist about your positive TB Skin test?

☐ Yes → **Attach documentation if available**
☐ No

Have you had an IGRA test?

☐ Yes Result: ☐ Negative ☐ Positive

Date of Test:
→**Attach result**
☐ No

Have you been treated for Latent TB Infection (LTBI)?

☐ Yes Medication:
Length of Treatment:
Date completed: _____
☐ No

IMPORTANT INFORMATION:

To prevent a significant reaction, **you must avoid having additional TB Skin Tests.**

It is recommended that you maintain a personal record of your TB Skin Test and Chest X-Ray for future reference.

Should you develop signs or symptoms of active TB you must seek medical attention immediately.

Signature:

Date