Region of Peel
working with you

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: ❑ M ❑ F ❑ Other ❑ Transgender ❑ Unknown
Address			Telephone No. Home:		Bus:	
City	Postal Code		Country of Birth	Date of Arrival in Canada Yr.	Mo.	Day

TB Skin Test Date _____ Result _____ mm
TB Skin Test Date _____ Result _____ mm

History of BCG ❑ Yes (Approximate age given) _____ ❑ No

Chest X-Ray Date _____ ❑ Abnormal ❑ Normal

HIV Testing Date _____ Result _____
IGRA Testing Date _____ Result _____

Reason for TB Skin Test

- ❑ Routine (includes volunteer, school, employment purposes)
- ❑ Contact of a case
- ❑ Symptoms (specify)

Referral to a Specialist ❑ **Yes** ❑ **No**

Name of specialist: _____

Medical Risk Factors ❑ **Yes** ❑ **No**

- ❑ HIV/AIDS
- ❑ Diabetes
- ❑ Renal Disease
- ❑ Immunosuppressive therapy / disease
- ❑ Other (specify): _____

Sputum sent for AFB and culture ❑ **Yes** ❑ **No**

Note: Drug orders will not be processed if culture results or consult notes from Specialists are pending

LTBI Treatment: ❑ accepted ❑ contraindicated ❑ declined

LTBI Treatment (please circle length of treatment):

❑	RMP	600	mg po daily x	4		months	
❑	RMP	450	mg po daily x	4		months	
❑	Vitamin B6	25	mg po daily x	6	9	12	months
❑	INH	300	mg po daily x	6	9	12	months
❑	INH syrup	_____	mg po daily x	6	9	12	months
❑	Other	_____					

Weight _____ **kg**

Recommended INH dosage for children is 10-15 mg/kg up to 300mg max.

Treatment Start Date (YYYY/MM/DD)

Initial Order Date _____
1st Repeat Date _____
2nd Repeat Date _____
3rd Repeat Date _____

Treatment End Date _____ (YYYY/MM/DD)

Reason Treatment Ended

❑ Adequate Treatment ❑ Non-adherent ❑ Never returned
❑ Side Effects ❑ Other

Patient Counselled: ❑ **Yes** ❑ **No**

- ❑ Signs and Symptoms of TB disease
- ❑ Side effects of TB Medications
- ❑ When to seek medical attention
- ❑ TB Pamphlets given

PLEASE FAX THE COMPLETED FORM AND COPY OF THE CHEST X-RAY REPORT TO:

FAX: (905) 565-8428

Peel Public Health
Communicable Disease Contol
Phone: (905) 791-7800 ext: 2796

Physician Name: _____
Address _____
_____
Phone No _____ **Fax** _____
Signature _____