

		TBPC Use Only – TBIS #		
Referring Physician/Nurse Practitioner		Phone	Fax	Referral Date (MMM-DD-YYYY)
<input type="checkbox"/> Urgent referral → consult TB physician on-call 306-655-1000 <input type="checkbox"/> Routine referral				
CLIENT DEMOGRAPHICS				
Last name		First name		Middle name
Date of birth (MMM-DD-YYYY)		Provincial health number	Phone (home)	(work)
Home address		City/Town/Community		Postal Code
Mailing address (if different than home address)		City/Town/Community		Province/Territory
Next of kin name		Next of kin relationship		Next of kin phone
Gender		Country of birth	Country of origin prior to arrival in Canada	Date of arrival
Is interpretation and translation required? <input type="checkbox"/> No <input type="checkbox"/> Yes → language(s):				
REASON FOR REFERRAL				
<input type="checkbox"/> Query active TB → urgent referral, consult TB physician on-call 306-655-1000 <input type="checkbox"/> Assessment for TB preventive treatment (treatment of TB Infection) <input type="checkbox"/> Tuberculin skin test only → Reason for skin test if requested: _____ <input type="checkbox"/> Tuberculin skin test and TB physician consult if test positive → Reason for skin test if requested: _____ <input type="checkbox"/> Other:				
HISTORY				
BCG vaccine <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Yes → Date if known (M/D/Y): _____ → BCG scar? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Tuberculin skin tests Date: _____ Result: _____ Date: _____ Result: _____				
IGRA Date: _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate				
Chest X-Ray <input type="checkbox"/> No <input type="checkbox"/> Yes → Date: _____ → <input type="checkbox"/> Available on PACS or other (specify): _____				
Symptoms <input type="checkbox"/> None <input type="checkbox"/> Cough (productive) <input type="checkbox"/> Cough (non-productive) <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight loss <input type="checkbox"/> Other (specify): _____				
Sputum for AFB x 3 requested? <input type="checkbox"/> No <input type="checkbox"/> Yes Note: Collect sputum if symptomatic, HIV positive, or abnormal CXR. Request TB PCR.				
Risk factors (tick all that apply) <input type="checkbox"/> None <input type="checkbox"/> Diabetes <input type="checkbox"/> Malnutrition (< 90% ideal body weight) <input type="checkbox"/> Alcohol use – amount: _____ <input type="checkbox"/> Fibronodular disease on CXR <input type="checkbox"/> Transplant (solid organ or hematopoietic) <input type="checkbox"/> Biologic drug therapy (anti-TNFs, DMARDs) – see below <input type="checkbox"/> Granuloma on CXR <input type="checkbox"/> Silicosis <input type="checkbox"/> Cancer – specify: _____ <input type="checkbox"/> HIV <input type="checkbox"/> Steroid therapy – amount: _____ <input type="checkbox"/> Cancer and on chemotherapy or stopped in last month <input type="checkbox"/> Less than 5 years of age <input type="checkbox"/> Tobacco use – amount: _____ <input type="checkbox"/> Stage 4 or 5 kidney disease (with or without dialysis) <input type="checkbox"/> TST conversion in last 2 years				
Biologic therapy – Anticipated start date if applicable (MMM-DD-YYYY): _____				
ADDITIONAL INFORMATION				

SEND REFERRAL DIRECTLY TO TB PREVENTION AND CONTROL SASKATCHEWAN
Saskatoon Tel. 306-655-1740
 Fax 306-655-1495

Prince Albert Tel. 306-765-4260
 Fax 306-765-4264

Regina Tel. 306-766-4311
 Fax 306-766-4710