



## Instructions for Tuberculosis (TB) Form

Healthcare professionals (HCPs) have a legislative duty to report notifiable and reportable diseases to the Chief Public Health Officer (CPHO) as required in the [NWT Public Health Act](#) (2009, SNWT 2007, c.17, SI-007-2009), with required information and timelines for reporting as defined in the [Disease Surveillance Regulations](#) (2009, R-096-2009). This information is used for territorial and national surveillance and informs public health planning and interventions. This reporting by the HCP is accomplished by submitting the NWT Tuberculosis (TB) Form to the Office of the Chief Public Health Officer (OCPHO). Information on cases of the following is reportable within specific time frames:

Type	Timeline for submitting the NWT TB Form to OCPHO after making a diagnosis or opinion
Tuberculosis Disease (TBD)	24 hours
Tuberculosis Infection <sup>1</sup> (TBI)	7 days

In addition to case information, HCPs shall make reasonable efforts to initiate contact tracing for individuals with TB disease within 24 hours of reportable disease diagnosis and provide the OCPHO with information respecting the contact tracing and specific control measures that have been initiated or carried out, as outlined the [Reportable Disease Control Regulations](#) (R-128-2009).

Contact tracing information is provided to the OCPHO on TB disease by filling out the [TB Investigation Contact Tracing Form](#) and submitting by medical confidential fax. Additional contact tracing information may be request depending on the circumstance.

## What to Report

Information within this reporting form is used for surveillance. It can help track the progression of an outbreak through different sub- populations (i.e., underhoused) as well as ensure that programs are meeting necessary TB standard indicators. Data from these sections are also used to fulfill reporting requirements to federal funders.

Case information for both TBD and TBI and should always be filled in:

- Section 1: Includes confirmed address and telephone number and reason for healthcare visit.
- Section 2: Includes TB history and IGRA/TST information
- Section 3: Includes symptoms, physical assessment, lab/radiological investigations, and current list of medications.
- Section 4: Includes risk factors that place the patient at higher risk for severe outcomes or converting to TBD.

Case information for TBD only:

- Section 5: Includes admission details, treatment completion, consultation notes and OCPHO direction for TBD.

Case information for TBI only:

- Section 6: Includes treatment assessment, treatment completion details and OCPHO direction for TBI.

**REQUIREMENT: For high risk or susceptible contacts who require an initial assessment and a follow-up assessment at 8 weeks, submit this form and check off the 8-week update in the table below.**

Note: If there is not enough room on the form to provide all information, please attached additional sheet with HCN on top right-hand corner.

### Important!

A NWT Tuberculosis (TB) Form, even if not fully complete, must still be reported (submitted) to the OCPHO within the timeframes identified above. It is expected that HCPs submit an *updated* form as new information is received. For example, it is unlikely that treatment will be fully complete within the initial reporting timeframe but will be completed later on these updates need to be reported (submitted) as information is provided.

Reporting Information	
Office of the Chief Public Health Officer Phone: (867) 920-8646   <b>Medical Confidential Fax: (867) 873-0442</b>	
Completed by:	(Sign)
Phone:	Date (dd/mmm/yyyy):
Comments:	
Report is: <input type="checkbox"/> Initial <input type="checkbox"/> Update <input type="checkbox"/> 8-week update	New information provided on section(s):

<sup>1</sup> TB Infection was formally known as Latent TB Infection (LTBI)  
Tuberculous (TB) Form Instructions



Completed report form (initial form and updates) should be sent to OCPHO by  
**Medical Confidential Fax: 867-873-0442**

Government of  
**Territories**

**NWT TUBERCULOSIS (TB) FORM**

**SECTION 1 – PATIENT INFORMATION**

<b>Affix Label</b>	<b>Last Name:</b>	<b>Gender:</b> <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Other <input type="checkbox"/> Not asked
	<b>First Name</b>	<b>Current occupation:</b>
	<b>HCN:</b>	<b>List all drug allergies:</b> _____
	<b>Birthdate (dd/mmm/yyyy):</b>	<b>Date of visit:</b> _____ <b>Location of visit:</b> _____
	<b>Sex at Birth:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex	<b>Reason for visit:</b> <input type="checkbox"/> Symptomatic/suspect (ex. cough, night sweats) <input type="checkbox"/> Positive TST/IGRA <input type="checkbox"/> Contact of a case <input type="checkbox"/> TBI treatment candidate <input type="checkbox"/> TB surveillance <input type="checkbox"/> General exam <input type="checkbox"/> Immigration screening <input type="checkbox"/> Occupational screening <input type="checkbox"/> Other: _____
<b>Current Address:</b>		

**SECTION 2 – TB HISTORY**

<b>Most recent TST (dd/mmm/yyyy):</b> _____ <input type="checkbox"/> N/A	<b>Previous TST (dd/mmm/yyyy):</b> _____ <input type="checkbox"/> N/A
<b>TST size mm (transverse only):</b> <input type="checkbox"/> Not read	<b>TST size mm (transverse only):</b> <input type="checkbox"/> Not read
<b>Received BCG:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, date (dd/mmm/yyyy): _____	<b>IGRA:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate (dd/mmm/yyyy): _____
	<b>IGRA:</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate (dd/mmm/yyyy): _____

**Previous treatment for disease or infection? Date (dd/mmm/yyyy) and details:**

**SECTION 3 – TB ASSESSMENT**

**3a) Symptoms (check all that apply add dd/mmm/yyyy after)**

<input type="checkbox"/> Fatigue (onset/duration):	<input type="checkbox"/> General malaise (onset/duration):	<input type="checkbox"/> Chest pain (onset/duration):
<input type="checkbox"/> Cough (onset/duration):	<input type="checkbox"/> Night sweats (onset/duration):	<input type="checkbox"/> Weight loss (onset/duration):
<input type="checkbox"/> Hemoptysis (onset/duration):	<input type="checkbox"/> Fever (onset/duration):	<input type="checkbox"/> Asymptomatic
<input type="checkbox"/> Other, details (onset/duration):		

**3b) Physical Assessment (check all that apply add dd/mmm/yyyy after)**

<input type="checkbox"/> Weight:	<input type="checkbox"/> Abnormal breath sounds:	<input type="checkbox"/> Enlarged lymph nodes:
<input type="checkbox"/> Signs of weight loss:	<input type="checkbox"/> Skin pallor:	<input type="checkbox"/> Red raised skin rash/lesions:

**3c) Lab/Radiological Investigations**

<input type="checkbox"/> Current chest x-ray (dd/mmm/yyyy): _____	<input type="checkbox"/> ALT, BUN, Total Bili, Creatinine (dd/mmm/yyyy): _____
Sputa collected: <input type="checkbox"/> No <input type="checkbox"/> Yes (dd/mmm/yyyy): _____	<input type="checkbox"/> Urine (R&M)/Urine Culture (dd/mmm/yyyy): _____
Pregnancy test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done	<input type="checkbox"/> HIV (dd/mmm/yyyy): _____
	<input type="checkbox"/> CBC and differential (dd/mmm/yyyy): _____

**3d) Current list of medications (list all)**

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**3e) Medical history**

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HCN: \_\_\_\_\_

**SECTION 4 – RISK FACTORS**

4a) Highest Risk	Positive	Negative	Unknown	Refused
HIV Status (last tested): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child or Adolescent TB Contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunocompromised Biologic <input type="checkbox"/> Steroid use <input type="checkbox"/> CA <input type="checkbox"/> Transplant Recipients <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Kidney Disease (with or without dialysis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4b) Immigration Information (if applicable)</b>				
Date of Arrival to Canada: _____	Country of Immigration: _____			
Spent time in refugee camp: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Country of Birth: _____			
Immigration Medical Exam number: _____				
Occupation: _____				
<b>4c) TB Exposure History</b>				
None <input type="checkbox"/> Unknown <input type="checkbox"/> Recent (within last 2 years) <input type="checkbox"/> Past exposure (more than 2 years)				
Contact of a case: <input type="checkbox"/> Household contact <input type="checkbox"/> Close non-household contact <input type="checkbox"/> Casual contact				
Date of last contact (dd/mmm/yyyy): _____				
Travel to High Incident Country in last 2 years: <input type="checkbox"/> No <input type="checkbox"/> Unknow <input type="checkbox"/> Yes, where: _____				
Details on past exposure (more than 2 years): _____				
<b>4d) Social Risk Factors</b>				
Number of people in household: _____	Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer			
Number of bedrooms: _____	Substance Use (any amount): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefer not to answer			
Fixed address? <input type="checkbox"/> Private/Rented Home <input type="checkbox"/> Shelter <input type="checkbox"/> Stay's with Friends <input type="checkbox"/> Homeless <input type="checkbox"/> Congregate living situation, date began living there: <input type="checkbox"/> Correctional facility, date of intake <input type="checkbox"/> Other: _____	<input type="checkbox"/> Alcohol (Frequency): <input type="checkbox"/> Other drugs (list): _____			
<b>4e) Suspect or Confirmed TB Disease</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, (dd/mmm/yyyy) <b>go to <a href="#">Section 5</a></b> :	<b>Confirmed TB Infection</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, (dd/mmm/yyyy) <b>go to <a href="#">Section 6</a></b> :			
	Is person willing to receive prophylactic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable, why? _____			



HCN:

**SECTION 5 – TB Disease**

<b>TB Diagnosis Date (dd/mmm/yyyy):</b>	<b>Positive</b>	<b>Negative</b>	<b>Site</b>
<b>Smear (dd/mmm/yyyy):</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Culture (dd/mmm/yyyy):</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Clinical diagnoses without lab confirmation, explain:</b>			
<b>Consultation with TB specialist completed:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, date (dd/mmm/yyyy):			
<b>Admitted to hospital:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, date (dd/mmm/yyyy)		<b>Deceased:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, date:	
<b>Discharged date (dd/mmm/yyyy):</b> <b>Where:</b>		<b>Discharge plan completed and communicated with new location:</b> <input type="checkbox"/> Yes, date: <input type="checkbox"/> No, why not:	

**TB Disease Treatment**

	Drug Name	Dosage	Route	Frequency	Initiated	Discontinued
<b>Intensive Phase</b>						
	<b>How many doses?</b>					
<b>Continuation Phase</b>						
	<b>How many doses?</b>					

<b>Treatment completed (dd/mmm/yyyy):</b>	<b>If not completed what % completed:</b> <input type="checkbox"/> >80% <input type="checkbox"/> 50-79% <input type="checkbox"/> <50% <input type="checkbox"/> Unknown
<b>Incomplete Treatment:</b> <input type="checkbox"/> deceased <input type="checkbox"/> Lost to follow-up, details on contacting: _____ <input type="checkbox"/> Left NWT, referral sent where: _____ date: _____ <input type="checkbox"/> Other: _____	<b>Notice to OCPHO on completion of treatment OR incomplete treatment:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, (dd/mmm/yyyy):

**HCP Notes:**

**OCPHO Notes (for OCPHO staff only)**



HCN:

**SECTION 6 – TB INFECTION**

**Is patient willing to accept treatment?**

Yes  No, reason:

**Any medical or social contra indications for treatment?**  Yes  No

Why:

**Have all required baseline labs/assessment been completed within 1 month prior to treatment start date?**  Yes  No

**TB Infection Treatment**

**Using 3HP?**  No  Yes (if using 3HP then must use DOPT 12 doses must be completed within 16 weeks.)

Drug Name	Dosage	Route	Frequency	Initiated	Discontinued

**Treatment completed (dd/mmm/yyyy):**

**How many doses provided:**

**What % completed:**  >80%  50-79%  <50%  Unknown

**How many missed dose:**  None  Amount:

**Incomplete Treatment:**  Side effects  Intolerance to drugs  
 Declined treatment  Deceased  Converted to TB disease  
 Lost to follow-up, details on contacting: \_\_\_\_\_  
 Left NWT, referral sent where: \_\_\_\_\_ date: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Notice to OCPHO on completion of treatment OR incomplete treatment:**  
 No  Yes, (dd/mmm/yyyy):

**HCP Notes:**

**Date (dd/mmm/yyyy):**

**HCP Signature:**

**OCPHO Notes/Recommendations (for OCPHO staff only)**

**Date (dd/mmm/yyyy):**

**OCPHO Signature:**