Government of
Northwest Territories

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[1] (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 | **Medical Confidential Fax: (867) 873-0442**	
Completed by:	**(Sign)**
Phone:	**Date (dd/mmm/yyyy):**
Comments:	
Report is: ☐ Initial ☐ Update ☐ 8-week update	**New information provided on section(s):**

[1] TB Infection was formally known as Latent TB Infection (LTBI)

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

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NWT TUBERCULOSIS (TB) FORM

SECTION 1 – PATIENT INFORMATION

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

SECTION 2 – TB HISTORY

Most recent TST (dd/mmm/yyyy): _____ ☐N/A	**Previous TST (dd/mmm/yyyy):** _____ ☐N/A
TST size mm (transverse only): ☐ Not read	**TST size mm (transverse only):** ☐ Not read
Received BCG: ☐No ☐Yes, date (dd/mmm/yyyy):	**IGRA:** ☐ Negative ☐ Positive ☐ Indeterminate **(dd/mmm/yyyy):** _____
	IGRA: ☐ Negative ☐ Positive ☐ 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)

☐Fatigue (onset/duration):	☐General malaise (onset/duration):	☐Chest pain (onset/duration):
☐Cough (onset/duration):	☐Night sweats (onset/duration):	☐Weight loss (onset/duration):
☐Hemoptysis (onset/duration):	☐Fever (onset/duration):	☐Asymptomatic
☐Other, details (onset/duration):		

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

☐Weight:	☐Abnormal breath sounds:	☐Enlarged lymph nodes:
☐Signs of weight loss:	☐Skin pallor:	☐Red raised skin rash/lesions:

3c) Lab/Radiological Investigations

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

3d) Current list of medications (list all)

3e) Medical history

	HCN:

SECTION 4 – RISK FACTORS

4a) Highest Risk	Positive	Negative	Unknown	Refused
HIV Status (last tested): _____	☐	☐	☐	☐
Child or Adolescent TB Contact	☐	☐	☐	☐
Immunocompromised Biologic ☐Steroid use ☐CA ☐Transplant Recipients ☐Other: _____	☐	☐	☐	☐
Chronic Kidney Disease (with or without dialysis)	☐	☐	☐	☐
Diabetes Mellitus	☐	☐	☐	☐

4b) Immigration Information (if applicable)	
Date of Arrival to Canada:	**Country of Immigration:**
Spent time in refugee camp: ☐Yes ☐No ☐Unknown	**Country of Birth:**
Immigration Medical Exam number:	
Occupation:	

4c) TB Exposure History
None ☐Unknown ☐Recent (within last 2 years) ☐Past exposure (more than 2 years)
Contact of a case: ☐Household contact ☐Close non-household contact ☐Casual contact **Date of last contact (dd/mmm/yyyy)**:
Travel to High Incident Country in last 2 years: ☐No ☐Unknow ☐Yes, where:
Details on past exposure (more than 2 years):

4d) Social Risk Factors	
Number of people in household: _____	**Smoker:** ☐Yes ☐No ☐Prefer not to answer
Number of bedrooms: _____	**Substance Use (any amount):** ☐Yes ☐No ☐Prefer not to answer
Fixed address? ☐Private/Rented Home ☐Shelter ☐Stay's with Friends ☐Homeless ☐Congregate living situation, date began living there: ☐Correctional facility, date of intake ☐Other:	☐Alcohol (Frequency): ☐Other drugs (list):
4e) Suspect or Confirmed TB Disease ☐No ☐Yes, (dd/mmm/yyyy) **go to Section 5**:	**Confirmed TB Infection** ☐No ☐Yes, (dd/mmm/yyyy) **go to Section 6**: **Is person willing to receive prophylactic treatment?** ☐Yes ☐No ☐Unable, why? _____

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HCN:	

SECTION 5 – TB Disease

TB Diagnosis Date (dd/mmm/yyyy):	Positive	Negative	Site
Smear (dd/mmm/yyyy):	☐	☐	
Culture (dd/mmm/yyyy):	☐	☐	

Clinical diagnoses without lab confirmation, explain:

Consultation with TB specialist competed: ☐No ☐Yes, date (dd/mmm/yyyy):

Admitted to hospital: ☐No ☐Yes, date (dd/mmm/yyyy)	**Deceased:** ☐No ☐Yes, date:
Discharged date (dd/mmm/yyyy): Where:	**Discharge plan completed and communicated with new location:** ☐Yes, date: ☐No, why not:

TB Disease Treatment

	Drug Name	Dosage	Route	Frequency	Initiated	Discontinued
Intensive Phase						
	How many doses?					
Continuation Phase						
	How many doses?					

Treatment completed (dd/mmm/yyyy):	**If not completed what % completed:** ☐>80% ☐50-79% ☐<50% ☐Unknown
Incomplete Treatment: ☐deceased ☐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:

OCPHO Notes (for OCPHO staff only)

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SECTION 6 – TB INFECTION

Is patient willing to accept treatment? ☐Yes ☐No, reason:	**Any medical or social contra indications for treatment?** ☐Yes ☐No Why:

If no for either of the above questions, please still submit form and contact Territorial Public Health for direction on how to add to TB community surveillance.

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:**