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Medical Officer of Health

Reply: Toronto Public Health - Unit T
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Notification of Active Tuberculosis Disease

Patient's Surname	Given Names	Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	DOB Y ___ M ___ D ___	OHIP#
Address:	Postal Code	Home Telephone # ()	Bus. Telephone # ()	Cell Telephone # ()
Hospital Admission <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Hospital	Admission Date Y ___ M ___ D ___	Discharge Date Y ___ M ___ D ___	

Family Physician:	Telephone number:
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<p align="center">Diagnosis</p> <p>Date Y ___ M ___ D ___</p> <p><input type="checkbox"/> Pulmonary <input type="checkbox"/> Primary Pulmonary <input type="checkbox"/> Pleural <input type="checkbox"/> Skin <input type="checkbox"/> Miliary <input type="checkbox"/> Abdominal <input type="checkbox"/> Bone/Joint <input type="checkbox"/> C.N.S. <input type="checkbox"/> Genito-urinary <input type="checkbox"/> Lymph Node <input type="checkbox"/> Other (specify): _____</p> <p>Has the Diagnosis been discussed with the client? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p align="center">Symptom Onset</p> <p>Date: Y ___ M ___ D ___</p> <p align="center">Method of Detection</p> <p><input type="checkbox"/> Immigration <input type="checkbox"/> Contact <input type="checkbox"/> Routine Check-up <input type="checkbox"/> Symptoms – (specify) <input type="checkbox"/> Cough >3weeks <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Fever/Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Unexplained weight loss <input type="checkbox"/> Fatigue</p>
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<p align="center">History</p> <p><input type="checkbox"/> New Active <input type="checkbox"/> Previously Treated TB (documented treatment)</p> <p>Date previously diagnosed: _____ Country previously diagnosed in: _____ Previous Treatment Regimen: _____</p>	<p>CHEST X-RAY (within the last 3 months): (Please attach CXR Report)</p> <p>Date: Y ___ M ___ D ___</p> <p><input type="checkbox"/> Normal <input type="checkbox"/> Cavitory <input type="checkbox"/> Non-Cavitory _____</p>
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<p>Lab Results *Please attach copy of pathology report</p> <table border="1"> <thead> <tr> <th>Test</th> <th>Specimen</th> <th>Result</th> <th>Date</th> </tr> </thead> <tbody> <tr> <td>Smear</td> <td></td> <td></td> <td></td> </tr> <tr> <td>PCR</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Culture</td> <td></td> <td></td> <td></td> </tr> <tr> <td>*Pathology</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other:</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Test	Specimen	Result	Date	Smear				PCR				Culture				*Pathology				Other:				<p>Patients with TB/HIV co-infection are diagnosed every year in Toronto. All TB patients should be tested for HIV. HIV Test Date: _____ Result: _____</p> <hr/> <p>Was this case discovered after death? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Date: Y ___ M ___ D ___ <input type="checkbox"/> TB – Cause of death <input type="checkbox"/> TB – Incidental Finding <input type="checkbox"/> TB Contributed but not cause of death</p>
Test	Specimen	Result	Date																						
Smear																									
PCR																									
Culture																									
*Pathology																									
Other:																									

TB Medication is FREE through Public Health: Current Weight _____ kg

Description	Strength Available	Quantity per Bottle	Prescription	Total Number of Months (TPH will Dispense)
Isoniazid Tablet (or syrup)	300 mg	100	Standard dosage: <input type="checkbox"/> 300 mg oral daily Other dosage: <input type="checkbox"/> _____ mg oral _____	
	100 mg	100		
	50 mg/5ml (syrup)	500 ml		
Pyridoxine Hydrochloride (B6) Tablet	25 mg	100	Standard dosage: <input type="checkbox"/> 25 mg oral daily Other dosage: <input type="checkbox"/> _____ mg oral _____	
Rifampin Capsule	300 mg	100	Standard dosage: <input type="checkbox"/> 600 mg oral daily Other dosage: <input type="checkbox"/> _____ mg oral _____	
	150 mg	100		
Pyrazinamide Tablet	500 mg	120	Weight based dosage _____ mg oral _____ Adult 20-25 mg/kg daily Child 30-40 mg/kg (max. 2 g) daily	
Ethambutol Hydrochloride Tablet	400 mg	100	Weight based dosage _____ mg oral _____ Adult 15-20 mg/kg daily Child 15-25 mg/kg (max. 1600 g) daily	
	100 mg	100		

Treating Physician (please print): Name: _____ Address: _____ Tel: _____	Date: Y ___ M ___ D ___ Signature: _____ Billing #: _____ Next scheduled appointment: _____
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