Positive Tuberculin Skin Test (TST)
Physician Referral Form

Employee Name: _____ Date of Birth (MM/DD/YYYY): _____ Age: _____ PHIN: _____ MHSC:_____ Country of Birth: _____ Province: _____ Year of/or age at immigration: _____ First Nation: (circle) Yes No	Facility of Hire: _____ Department: _____ Position: _____ Employee Phone Number: _____ Employee Cell Phone Number: _____ Employee Work Number: _____
TST Reaction Size: Date: _____ Size: _____ Date: _____ Size: _____	Date: _____ Size: _____
BCG Status: Never Vaccinated: _____ Scar Present: _____	Vaccinated age < 2 years: _____ Vaccinated age > 2 years: _____
Contact with Active TB: Yes _____ No _____	Describe: _____ _____
Past Treatment for TB: Yes _____ No _____	Describe: _____ _____
Please select all conditions that currently apply:	
☐ Cough > 3 weeks duration ☐ Fever > 3 weeks duration ☐ Night sweats ☐ Hoarseness ☐ Unexplained weight loss ☐ Chest pain ☐ Bloody sputum ☐ Underweight (<90% of ideal body weight) ☐ Carcinoma of head and neck ☐ Diabetes Mellitus ☐ HIV Infection	☐ Cigarette smoker (>1 pack/day) ☐ Immunosuppressant (Prednisone, Remicade, Infliximab, others) Name and Dosage: _____ ☐ Silicosis ☐ Transplant (related to immunosuppressant therapy) Other major medical conditions: _____ _____ _____ Education: Signs and Symptoms of LTBI: _____
High risk work or travel history:	Chest x-ray date: _____ Result: _____ Respiratory Clinic: _____ _____ Referred to: _____

Occupational Health Nurse Name: _____ Occupational Health Nurse Signature: _____ Date: _____

Physician Plan/Diagnosis:
_____
_____
_____

Physician Name: _____ Physician Signature: _____ Date: _____