

Tuberculin Skin Test Screening Record

Quick Guide for Completing the Form

WHEN TO REPORT

Report **all** positive and negative tuberculin skin test (TST) results to TB Prevention and Control Saskatchewan (TBPC SK) with the **exception** of testing performed off-reserve for the purposes of travel, employment/occupational health or post-secondary education requirements. The screening assessment on the reverse side of the screening record does not need to be faxed to TBPC SK.

Section 1: PATIENT INFORMATION

Patient identifiers: Include a minimum of three – full name, provincial health number and date of birth. The patient's gender must also be noted.

Contact information: For follow up purposes, include the patient's full address and phone number(s).

BCG: Record the year if the person received the BCG vaccination. Knowing if, and when, a person received the BCG vaccination assists with test interpretation.

Family Physician: Refer the patient to their family physician or nurse practitioner for medical evaluation if the size of the reaction is considered positive and the test was completed for employment, education, or travel purposes.

Health-care Provider Requesting TST: Fax the completed screening record to the requesting provider to ensure follow-up and referral, if needed. This is usually a physician (example: when testing is performed prior to starting biologic therapy or organ transplantation).

Section 2: REASON FOR SCREEN

Assists with processing, interpretation and overall management of persons being screened. TBPC SK may request screening results be documented on an alternate form when the person is a contact to an infectious case.

Section 3: ADMINISTRATION

Complete the screening assessment on the reverse side of the screening record prior to administering the TST to determine the appropriateness of testing, the client's eligibility and to assist with interpretation of test results.

Date and time (given and read): Knowing the timeframe between TST administration and reading assists with interpretation of results. Reading should be performed 48 to 72 hours after administration. Tests read after 72 hours and considered positive will be accepted; the TST will not need to be repeated.

Site of injection: Helps with getting an accurate result especially when another health professional reads the TST.

Symptoms: Record symptoms of active TB regardless of TST result. Ensure referral for medical evaluation if symptomatic. Contact TBPC SK if questions. Note: 20-30% of persons with active TB have a negative TST at the time of diagnosis.

Result: Record the result in millimetres and as a whole number. Do not use fractions, terms or signs such as positive, negative, nil, the null sign (\emptyset) or greater/lesser-than signs ($>$ or $<$). Record as 0 mm if no induration.

Is the size of the reaction considered positive: Refer to the table on the reverse side of the screening record to determine if the size of the reaction is considered positive. This helps determine if the person needs a 2-step TST and/or medical evaluation. It also helps avoid testing someone with a previously **documented** positive reaction in future.

Repeat TST: Use this section to document the second TST if a 2-step TST is required or if an eight week contact investigation follow-up TST is being completed.

Previous TST if known: This information helps determine if a client is eligible for testing and assists with interpretation.

Section 4: COMMENTS

Record adverse reactions such as anaphylaxis and severe blistering reactions, allergy to any component of the tuberculin PPD, any follow-up care or referrals, and other applicable information.



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103 Hospital Drive
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Phone: 306-655-1740
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Prince Albert Office
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Prince Albert SK S6V 0V7
Phone: 306-765-4260
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Regina Office
Regina General Hospital
1440 – 14th Avenue
Regina SK S4P 0W5
Phone: 306-766-4311
Fax: 306-766-4710

TUBERCULIN SKIN TEST SCREENING RECORD

TBPC Use Only – TB File _____

Section 1

Last Name		First Name		Middle Initial	Other Name(s)	
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth (y/m/d)		Provincial Health Number		Treaty/Band Number	
Address (Street/PO Box)			City/Town/Community		Postal Code	Province
Phone (Home)		(Work)		(Cell)		
BCG (year)	Family Physician <input type="checkbox"/> None		Health-care Provider Requesting TST (if applicable)			

Section 2

REASON FOR SCREEN (tick all that apply)

Contact Contact to (name or TB file #): _____ Last contact date (y/m/d) _____

Correctional facility resident Employment Immigration High risk medical condition (specify) _____

Pre Anti-TNF therapy Pre-school/School Pre Transplant Other (specify) _____

Section 3

ADMINISTRATION

Initial TST					
Date given (y/m/d)	Time (hours)	Site of injection	Tubersol PPD 5 TU (0.1 mL) – Lot #	SYMPTOMS	
Given by	Title/Position		<input type="checkbox"/> None <input type="checkbox"/> Fever <input type="checkbox"/> Cough (productive) <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Cough (non-productive) <input type="checkbox"/> Night sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight loss <input type="checkbox"/> Other (specify) _____		
Test Centre			Phone		
Result (mm)	Date read (y/m/d)	Time (hours)	Read by	Title/Position	Phone

Is the size of the reaction considered positive (refer to table on reverse side)? Yes No Unknown

Repeat TST (e.g., if two-step TST)

Date given (y/m/d)	Time (hours)	Site of injection	Tubersol PPD 5 TU (0.1 mL) – Lot #	SYMPTOMS	
Given by	Title/Position		<input type="checkbox"/> None <input type="checkbox"/> Fever <input type="checkbox"/> Cough (productive) <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Cough (non-productive) <input type="checkbox"/> Night sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight loss <input type="checkbox"/> Other (specify) _____		
Test Centre			Phone		
Result (mm)	Date read (y/m/d)	Time (hours)	Read by	Title/Position	Phone

Is the size of the reaction considered positive (refer to table on reverse side)? Yes No Unknown

Previous TST if known

Result (mm)	Date (y/m/d)	Test Centre
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Section 4

COMMENTS (if applicable include adverse reactions, allergies, if sputum sent, if referred to family physician)

TBPC RN USE ONLY

Date reviewed: No follow up required Physician order sent Refer to family physician for evaluation
 Letter sent to primary care provider CXR required Referral to TBPC required
 Letter sent to client Sputum required Schedule TBPC clinic appointment

Original: Health Record
TBPC SK 2015-10-25

Copy: TB Prevention & Control SK

Entered in Panorama: _____

Entered in TBIS: _____

