RÉGIE RÉGIONALE DE LA SANTÉ ET DES SERVICES SOCIAUX DU NUNAVIK / NUNAVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES

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UNGAVA TULATTAVIK HEALTH CENTER
CENTRE DE SANTÉ TULATTAVIK DE L'UNGAVA

CLINICAL ASSESSMENT OF A SUSPECTED ACTIVE TB CASE OR A CONTACT OF ACTIVE TB CASE

EMBOSSER ICI LA CARTE DU CSI OU CSTU,
SI NON DISPONIBLE, INSCRIRE LES NOM, PRÉNOM,
DATE DE NAISSANCE ET NUMÉRO DOSSIER

EMBOSS IHC OR UTHC CARD HERE
IF NOT AVAILABLE, WRITE THE NAME, SURNAME,
DATE OF BIRTH AND FILE NUMBER

Section 1: PERSONAL INFORMATION

Sex: ☐ M ☐ F Telephone no.: ____________ Facebook account or e-mail: ____________________
House no.: ______________ No. of residents: ___________ No. of bedrooms: _________

Reason for assessment: ☐ Contact of active case ☐ Search for source case ☐ Professional's request
☐ Patient's request ☐ Other: ___________________________

INDEX CASE Date of birth: yyyy / mm / dd File no.: ____________ Date of diagnosis: yyyy / mm / dd
CXR information: ☐ Cavitary ☐ Non-cavitary BK: ☐ Smear (+) ☐ Smear (–) ☐ Culture (+) ☐ Culture (–) ☐ Unknown

CONTACT LOCATION AND DETAILS *(more than one answer possible)*
☐ House of index case ☐ Other house ☐ Workplace ☐ School/Day-care ☐ Social group ☐ Other: ________________
Contact location(s) (specify, e.g., house no., primary school/class, employer): _________________________________
If *House of index case* or *Other house*, do they sleep in same bedroom? : ☐ N ☐ Y
Frequency of contact[1] (per week): ________ Duration of contact: ________ hrs Date of last contact: yyyy / mm / dd

HISTORY
BCG vaccination: ☐ N ☐ Y Date(s): yyyy / mm / dd yyyy / mm / dd yyyy / mm / dd
Previous active TB: ☐ N ☐ Y Year: _______ Treatment completed ☐ N ☐ Y Compliant (%) ________
Previous LTBI: ☐ N ☐ Y Year: _______ Treatment completed **INH** or **RIF** ☐ N ☐ Y Compliant (%) ________
Previous TST[2]: ☐ N ☐ Y Date: yyyy / mm / dd Result:____ *mm* Date: yyyy / mm / dd Result: ____ *mm*
Date: yyyy / mm / dd Result: ____ *mm* Date: yyyy / mm / dd Result: ____ *mm*
Previous Quantiferon: ☐ N ☐ Y Date: yyyy / mm / dd Result:________ Date: yyyy / mm / dd Result: _______

CURRENT MEDICAL PROBLEMS ☐ None ☐ Unknown ☐ Other: ___________________
☐ Known allergy to TB medication ☐ Head/neck cancer ☐ Diabetes ☐ Organ recipient under treatment immunosuppressive
☐ Chronic kidney failure ☐ Liver disease ☐ Immunodeficiency

MEDICATIONS CURRENTLY TAKEN ☐ None ☐ Other: ____
☐ Anticonvulsive (specify): ________________________ ☐ Hormonal contraceptive (specify): _______________________
☐ Corticosteroids (specify): _______________________ ☐ Immunosuppressive (specify): ___________________________
Pregnant? ☐ N ☐ Y ☐ N/A

------------------------- **Once information is completed, send Section 1 to DPH[3]** -----------------------------

Section 2: RISK FACTORS

Smoking ☐ N ☐ Y Cigarettes per day: ________________
Alcohol use ☐ N ☐ Y Quantity/Frequency: _______________
Cannabis use ☐ N ☐ Y Quantity/Frequency: _______________ Location: ______________
Presence at gathering places ☐ N ☐ Y (e.g., gambling establishments, cannabis use in groups, etc.)
Specify locations if possible (house no., owner name): ____________________________________

OTHER RISK FACTORS in past two years: ☐ None
☐ Homeless (urban setting)
☐ Prior incarceration, specify locations/dates: ____
☐ Stay in other Nunavik communities/Nunavut/outside region, specify locations/dates: ___________________________

[1] **Important: indicate frequency** (number of visits per week), **duration** (usual number of hours of such visits) and **date of last contact**.
[2] Do not include tine test.
[3] DPH addresses: tuberculose-santepublique.nrbhss@ssss.gouv.qc.ca and vannessa.jean-marie.ciussscn@ssss.gouv.qc.ca

Last name: _____ First name: _____ File no.: _____

Section 3: INITIAL CLINICAL ASSESSMENT

SYMPTOMS

Unusual cough > 3 weeks	☐ N ☐ Y	Start date: yyyy / mm / dd			
Expectorations	☐ N ☐ Y	Duration _____ *weeks*	Chest pain	☐ N ☐ Y	Duration _____ *weeks*
Hemoptysis	☐ N ☐ Y	Duration _____ *weeks*	Persistent fever	☐ N ☐ Y	Duration _____ *weeks*
Dyspnea	☐ N ☐ Y	Duration _____ *weeks*	Night sweats	☐ N ☐ Y	Duration _____ *weeks*
Unexplained weight loss	☐ N ☐ Y	_____ kg	Fatigue	☐ N ☐ Y	Duration _____ *weeks*

Other: _____

PHYSICAL EXAMINATION

Current weight: _____kg — Previous weight: _____kg — Date: yyyy / mm / dd

Pulmonary auscultation: ☐ Normal ☐ Abnormal — Specify: _____

Physical examination (adenopathy, erythema nodosum): — Specify: _____

Date of assessment: yyyy / mm / dd — Nurse: _____

Attenuated live vaccine *(MMR, MMR-chickenpox, zoster, typhoid, Flumist)* received in past four weeks[4]: ☐ N ☐ Y → Date: yyyy / mm / dd

TST #1 required[5] ☐ N ☐ Y TST performed on: yyyy / mm / dd Time: _____ Lot no.: _____ Site: _____ Nurse: _____

TST interpreted on: yyyy / mm / dd Time: _____ TST result: _____ mm Nurse: _____

---------- At end of initial clinical assessment, send Sections 1-2-3 to DPH[3] ----------

Section 4: FOLLOW-UP CLINICAL ASSESSMENT[6]

Scheduled date: yyyy / mm / dd

SYMPTOMS

Unusual cough > 3 weeks	☐ N ☐ Y	Start date: yyyy / mm / dd			
Expectorations	☐ N ☐ Y	Duration _____ *weeks*	Chest pain	☐ N ☐ Y	Duration _____ *weeks*
Hemoptysis	☐ N ☐ Y	Duration _____ *weeks*	Persistent fever	☐ N ☐ Y	Duration _____ *weeks*
Dyspnea	☐ N ☐ Y	Duration _____ *weeks*	Night sweats	☐ N ☐ Y	Duration _____ *weeks*
Unexplained weight loss	☐ N ☐ Y	_____ kg	Fatigue	☐ N ☐ Y	Duration _____ *weeks*

Other: _____

PHYSICAL EXAMINATION

Current weight: _____kg

Pulmonary auscultation: ☐ Normal ☐ Abnormal Specify: _____

Physical examination (adenopathy, erythema nodosum): Specify: _____

Date of assessment: yyyy / mm / dd Nurse: _____

Attenuated live vaccine *(MMR, MMR-chickenpox, zoster, typhoid, Flumist)* received in past four weeks[4]: ☐ N ☐ Y → Date: yyyy / mm / dd

TST #2 required ☐ N ☐ Y TST performed on: yyyy / mm / dd Time: _____ Lot no.: _____ Site: _____ Nurse: _____

TST interpreted on: yyyy / mm / dd Time: _____ TST result: _____ mm Nurse: _____

Section 5: MEDICAL COURSE OF ACTION

CXR required[7] ☐ N ☐ Y Date CXR performed: yyyy / mm / dd

BK x 3 required ☐ N ☐Y Dates: GeneXpert yyyy / mm / dd

Expecto #1 yyyy / mm / dd Expecto #2 yyyy / mm / dd Expecto #3 yyyy / mm / dd

Medical follow-up:

☐ Release
☐ Clinical-radiological follow-up
☐ Active TB treatment
☐ LTBI treatment
☐ Window-period prophylaxis

Clinical impression:

_____

_____

PHYSICIAN'S SIGNATURE: _____ DATE: yyyy / mm / dd

---------- At end of investigation, send this form to DPH[3] ----------

[4] If yes, administer TST on same day or four weeks after administration of vaccine in question (refer to *PIQ*).

[5] For a child < 5 years vaccinated with BCG and identified as contact: if LTBI not confirmed and asymptomatic with normal CXR, **perform TST only at eight weeks after last contact (= at end of window period).**

[6] To be performed if TST # 2 required or at physician's request. Enter scheduled date of appointment in agenda.

[7] Any 3-projection CXR performed on individual ≥ 5 years old during 3 months preceding diagnosis of presumed source case may be considered as initial CRX and not to be repeated during investigation, on condition this individual **remains asymptomatic and presumed source case has a negative smear.**