**POST-EXPOSURE TB UPDATE**

**HEALTH PROFESSIONAL PROGRAMS**

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**TB Exposures – Student to complete this section:** Do any of the following apply since your last negative TB screening?

- [ ] Yes  [ ] No  
  **Significant exposure to an individual with active (infectious) TB disease (i.e. lived with or had an intimate relationship with someone with active TB, or notified by Occupational Health or Public Health about possible exposure to active TB).**

- [ ] Yes  [ ] No  
  **Clinical placement in a country with a high incidence TB (30 or more cases per 100,000).**

  Exposure criteria for post-travel TB testing:
  - $\geq 1$ month of travel to TB incidence country $\geq 30/100,000$ population with high-risk contact, particularly direct patient contact in a hospital or indoor setting, but possibly including work in prisons, homeless shelters, refugee camps or inner-city slums.
  - $\geq 3$ months of travel to TB incidence country $> 400/100,000$ population
  - $\geq 6$ months of travel to TB incidence country 200-399/100,000 population
  - $\geq 12$ months of travel to TB incidence country 100-199/100,000 population

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If “No” applies to all questions: STOP HERE, this form is not required.

If “Yes” applies to one or more questions: Attach documentation of a single TST eight or more weeks post-exposure OR have a qualified health care professional (HCP) complete below:

**TST negative:** STOP HERE.

**TST positive:** Attach a copy of a chest x-ray report dated subsequent to the positive test. Students must report the positive result to their program manager and withdraw from clinical activities until they are cleared by the Health Screening Office. Students with a negative chest x-ray and no symptoms of active TB disease will be cleared for participation in clinical activities with no restriction.

Student to verify the following: I verify that I do not currently have any symptoms of active TB disease (cough lasting three or more weeks; hemoptysis; shortness of breath; chest pain; fever; chills; night sweats; unexplained or involuntary weight loss).

Student signature: ____________________________  Date: ____________________________

NOTE: A positive TST must be reported to Public Health Services by the HCP. Referral may be made to the TB Clinic at St. Joseph’s Healthcare: Tel: 905-522-1155 Ext 34198, Fax: 905-525-5806.

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<table>
<thead>
<tr>
<th>DATE TST given</th>
<th>DATE TST read</th>
<th>mm induration</th>
<th>Interpretation</th>
<th>HCP Initials</th>
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**HCP Information:**

Name: ____________________________  Profession: _________  Initials _________

Signature: ____________________________  Date: ____________________________

Office stamp or address/telephone:

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Health Screening Office, MDCL 3514, 1280 Main Street West, Hamilton ON L8S 4K1, (905) 525-9140 ext 22249, fax 905-528-4348