

## Appendix 3: Protocol for TB symptom screening form and referral

This tool will be helpful in determining what actions to take. If you have any questions or concerns after completing the form, call Toronto Public Health's TB Program: 416-338-7600.

**Persons to be screened:** Users of shelters or drop-in centres who have a new or worsening cough lasting longer than three weeks and are not receiving regular medical or nursing care.

**Who should do the screening?** A worker designated by the agency. All staff should be aware of, and alert to, the signs and symptoms of TB.

**Complete the form:** Symptom screening for TB.

### Assess symptoms of active TB disease

- Early signs and symptoms of TB include unexplained weight loss, loss of appetite and fatigue.
- Later, the person may develop a new or worsening cough (lasting longer than three weeks), fever, chills and night sweats. A person who has TB disease may show some, all, or none of the symptoms.

### Referral

- If client reports a new or worsening cough that has lasted longer than three weeks, promptly refer them to a clinic or healthcare professional. Give the client a surgical mask to wear. Call the clinic or healthcare professional's office to alert them that a person with possible TB is coming so that precautions may be taken.
- While still at the shelter, in addition to wearing a surgical mask, the client should be in a separate room away from other clients. The staff member providing direct support to the client should wear an N95 mask. The staff member wearing an N95 mask must have been previously fit-tested.
- If the person does not have an Ontario Health Card and/or a regular healthcare professional, refer them to a Community Health Centre in the area where they live. You can also contact Toronto Public Health for help with making a referral.
- If the client is ill enough that they need to be seen in an emergency room, call ahead to the emergency room to let them know that someone with possible TB is coming. If the client requires transport by ambulance, inform the paramedics that the client may have TB.
- If the client refuses to go to a healthcare professional, sputum should be collected (Public Health TB staff can assist).

### If a client is refusing a referral:

- All efforts should be made to convince the client to have a medical assessment.
- If an ill client refuses all care (i.e. will not go to a healthcare professional, will not provide sputum, will not go to emergency) isolate the client (if possible) and call Toronto Public Health TB Program at 416-338-7600, or for after hours emergencies: 311.

# Symptom screening for Tuberculosis (TB)

Name (last, first): \_\_\_\_\_ Gender:  M  F  Other \_\_\_\_\_

Address/Shelter: \_\_\_\_\_

\_\_\_\_\_ Telephone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of arrival in Canada: \_\_\_\_\_  
year month day year month day

Country of Birth: \_\_\_\_\_

1. **Have you ever had TB disease?**  NO  YES
2. **Have you ever had a TB skin test?**  NO  YES (If yes, date: \_\_\_\_\_ and result: \_\_\_\_\_)
3. **Do you have any of the following symptoms?**

New or worsening cough?	<input type="checkbox"/> NO <input type="checkbox"/> YES	How long? _____
Productive cough?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Colour? _____
Fever?	<input type="checkbox"/> NO <input type="checkbox"/> YES	How long? _____
Chills?	<input type="checkbox"/> NO <input type="checkbox"/> YES	How long? _____
Fatigue?	<input type="checkbox"/> NO <input type="checkbox"/> YES	How long? _____
Night sweats?	<input type="checkbox"/> NO <input type="checkbox"/> YES	How long? _____
Weight loss?	<input type="checkbox"/> NO <input type="checkbox"/> YES	How long? _____
Loss of appetite?	<input type="checkbox"/> NO <input type="checkbox"/> YES	How long? _____

4. **Are you taking any antibiotics now?**  NO  YES Name: \_\_\_\_\_

5. **Do you have any other illnesses?** \_\_\_\_\_

Name of your healthcare professional/clinic: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Telephone Number: \_\_\_\_\_

Name of interviewer: \_\_\_\_\_ Title: \_\_\_\_\_

Name of agency: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Date: \_\_\_\_\_