☐ **UNGAVA TULATTAVIK HEALTH CENTRE**
☐ **INNULITSIVIK HEALTH CENTRE**

CONSULTATION
IN DIAGNOSTIC RADIOLOGY
Tuberculosis (TB)

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

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

Examination requested: LUNGS
☒ Posteroanterior ☒ Lateral ☒ Lordotic

Previous examination ☐ Yes ☐ No
☐ Hospitalized ☐ Emergency ☐ External
☐ Outpatient ☐ Wheelchair ☐ Stretcher ☐ In bed

☒ Please read quickly | Pregnant patient ☐ Yes ☐ No

Last TST: _____*mm* Date **(yyyy/mm/dd)** : _____
☐ Previous active TB Year(s):_____
☐ Previous LTBI Year: _____

Expected date of CXR (yyyy/mm/dd): _____

Notes by nurses: _____
_____
_____
_____
_____

Comments from Doctor:

Signature: _____ License #: _____
Date of request (yyyy/mm/dd): _____

Specification: *Check only one of the following protocols:*

1. ☐ Suspicion of active TB without known TB contact
2. ☐ Investigation of asymptomatic TB contact
3. ☐ Investigation of symptomatic TB contact
4. ☐ Active TB treatment in progress: number months of tx
5. ☐ Pre-prophylaxis evaluation
6. ☐ Populational/targeted testing
7. ☐ Clinical-radiological follow-up (CRF):
   CXR #_____ of a series of number ad year ____
   a) ☐ CRF for post-treatment LTBI/Active TB
   b) ☐ CRF for inadequate prophylaxis
   c) ☐ CRF for postexposure (close contact) to a smear-positive TB case
   Date of last contact **(yyyy/mm/dd)**: _____

RADIOLOGY PROTOCOL (Section reserved for radiology technologist)

Number of images: _____ **Signature :** _____