

H6 ; Ybc hmd]b[' F Yei Ygh: cfa

Submitter Information		
Health Unit/Institution		
Address	City	Postal Code
Contact Person	Phone	Fax
Email		

Suspect Cluster: Patient Information					
1.	Last Name	First Name	DOB (yyyy-mm-dd)	HIN#	Diagnosis Date (yyyy-mm-dd)
PHL#	iPHIS#	Reason for suspected match:			Specify:
		<input type="checkbox"/> Family	<input type="checkbox"/> Workplace	<input type="checkbox"/> Known Contact	<input type="checkbox"/> Other
Match against:					Specify:
<input type="checkbox"/> Entire database					<input type="checkbox"/> Homeless cluster
					<input type="checkbox"/> Patient 2
					<input type="checkbox"/> Patient 3
					<input type="checkbox"/> Other
2.	Last Name	First Name	DOB (yyyy-mm-dd)	HIN#	Diagnosis Date (yyyy-mm-dd)
PHL#	iPHIS#	Reason for suspected match:			Specify:
		<input type="checkbox"/> Family	<input type="checkbox"/> Workplace	<input type="checkbox"/> Known Contact	<input type="checkbox"/> Other
Match against:					Specify:
<input type="checkbox"/> Entire database					<input type="checkbox"/> Homeless cluster
					<input type="checkbox"/> Patient 1
					<input type="checkbox"/> Patient 3
					<input type="checkbox"/> Other
3.	Last Name	First Name	DOB (yyyy-mm-dd)	HIN#	Diagnosis Date (yyyy-mm-dd)
PHL#	iPHIS#	Reason for suspected match:			Specify:
		<input type="checkbox"/> Family	<input type="checkbox"/> Workplace	<input type="checkbox"/> Known Contact	<input type="checkbox"/> Other
Match against:					Specify:
<input type="checkbox"/> Entire database					<input type="checkbox"/> Homeless cluster
					<input type="checkbox"/> Patient 1
					<input type="checkbox"/> Patient 2
					<input type="checkbox"/> Other

Additional Information
Additional Comments:

**Please fill in this form electronically, print, and then fax to the PHL
Toronto TB and Mycobacteriology laboratory at
416-235-6013**

For any questions please contact the TB laboratory at 647-792-3345.