Note: This is a fill and print form

BC Centre for Disease Control Society
Tuberculosis Control

# TUBERCULOSIS SCREENING PROGRAM

*Freedom of Information and Protection of Privacy Legislation (see reverse)*

**TB CONTROL USE ONLY**
NAME CODE | TB NUMBER | ☐ Mail ☐ Pickup

## PART 1 CLIENT COMPLETES

Use ballpoint and press hard

NAME ( FAMILY NAME) | GIVEN NAMES | MAIDEN NAME | DATE FORM INITIATED yyyy/mm/dd

ADDRESS No. and Street or P.O. Box | CITY/TOWN/MUNICIPALITY | PROVINCE | POSTAL CODE

HOME PHONE NUMBER | WORK PHONE NUMBER | GENDER ☐ Male ☐ Female | ETHNIC ORIGIN | FIRST NATION ☐ Registered ☐ Non-Registered ☐ On reserve ☐ Off reserve

DATE OF BIRTH yyyy/mm/dd | COUNTRY OR CANADIAN PROVINCE OF BIRTH | DATE ENTERED CANADA yyyy/mm/dd | PHYSICIAN'S NAME AND ADDRESS

## PART 2 NURSE COMPLETES

**REASON FOR EXAM** ***(see back of form for appropriate code)***

☐ **POPULATION AT RISK** Code _____ ☐ **GENERAL SCREENING** Code _____

**CONTACT INFORMATION**

☐ **TYPE 1** - Household or share the same air space for greater than 4 hours per/week

☐ **TYPE 2** - Non-household or share the same air space for 2-4 hous per/week

☐ **TYPE 3** - Casual or share the same air space for less than 2 hours per/week

NAME OF PERSON WITH TB OR TB# OR NAME CODE

DATE OF CONTACT yyyy/mm/dd

FIRST NATION SURVEY ☐ Yes ☐ No

**RISK FACTORS FOR DEVELOPING TB**

Diabetes ☐ Tx. with pills ☐ Tx. with insulin
☐ Cancer (type) _____
☐ Leukemia
☐ Lymphoma
☐ Kidney Disease
☐ HIV
☐ Transplant
☐ Prednisone
☐ None of the above

PAYMENT RECEIVED ☐

**SYMPTOMS**

☐ Cough ☐ Blood in sputum ☐ Fever ☐ Losing weight ☐ No symptoms
☐ Sputum ☐ Night sweats ☐ Fatigue ☐ Other concerns _____

**TUBERCULIN TESTING** *(see instructions on back - Part 2)*

**PREVIOUS BCG ?** ☐ Yes _____ (yyyy/mm/dd) ☐ No ☐ Uncertain BCG SCAR ? ☐ Yes ☐ No ☐ Uncertain

**DID NOT TEST:** ☐ Previous TB ☐ Previous Positive TBN ☐ Refused TBN

**TUBERCULIN TEST DONE**

| | | | | | |
|---|---|---|---|---|---|
| **INITIAL TEST:** | GIVEN BY: *(enter RHB/CHC/CHSS, Hospital or Health Centre code)* | DATE GIVEN: yyyy/mm/dd | DATE READ: yyyy/mm/dd | SIZE OF REACTION mm. | READ BY |
| | RECOMMENDATIONS: ☐ No further testing ☐ Repeat as required in _____ months ☐ Recommend X-Ray | | | | |
| **REPEAT TEST:** | GIVEN BY: *(enter RHB/CHC/CHSS, Hospital or Health Centre code)* | DATE GIVEN: yyyy/mm/dd | DATE READ: yyyy/mm/dd | SIZE OF REACTION mm. | READ BY READ BY |

**RECOMMENDATIONS:** ☐ No further testing ☐ Recommend X-Ray

## PART 3 NURSE COMPLETES

**HISTORY OF TB**

HAS CLIENT EVER HAD TB ? ☐ YES ☐ NO PREVENTATIVE TREATMENT? ☐ YES ☐ NO

HAS CLIENT EVER BEEN IN CONTACT WITH TB CASE PRIOR TO CURRENT EXPOSURE? ☐ YES IF YES, YEAR _____ MONTH _____ ☐ NO

RESULT OF LAST PREVIOUS TUBERCULIN TEST? ☐ NO INDURATION ☐ POSITIVE _____mm | WHEN? yyyy/mm/dd | WHERE?

**REASON FOR NOT HAVING CHEST X-RAY** ☐ PREGNANT ☐ REFUSED ☐ OTHER (specify)

## PART 4 PHYSICIAN COMPLETES

**CHEST X-RAY RESULT** ☐ Normal ☐ Abnormal

Comments:

**RECOMMENDATION AFTER X-RAY**

☐ No evidence of activeTB
☐ X-Ray tech. unsat. - Repeat
☐ See Doctor's report
☐ Incomplete (X-Ray/Report not received)
☐ TB Contact: Repeat CXR in _____ months
☐ Clinic appointment

TB CONTROL X-RAY NUMBER

RADIOLOGIST'S SIGNATURE DATE yyyy/mm/dd

TB PHYSICIAN'S SIGNATURE DATE yyyy/mm/dd



CLEAR FORM PRINT

| X-RAY DEPARTMENT COMPLETES | NAME OF CLIENT | DATE X-RAY GIVEN yy/mm/dd | X-RAY NUMBER |
|---|---|---|---|
| | NAME OF HOSPITAL OR RADIOLOGY DEPARTMENT TAKING X-RAY | | |

Note: Return x-ray unread with this form to: Division of tuberculosis control (for your region)

| | | |
|---|---|---|
| 655 West 12Ave.<br>Vancouver, B.C.<br>V5Z 4R4 | 80 St. Marys St.<br>New Westminister B.C.<br>V3L 1H6 | 1902 Fort St.<br>Victoria, B.C.<br>V8R 1J7 |

(Films from central and upper Vancouver Island regions should be sent to Vancouver)

Payment for chest x-ray will be for technical component only, not for reading of the x-ray and only for a PA film (no laterals).

**FREEDOM OF INFORMATION AND PRIVACY LEGISLATION**

The personal information collected on this form is used for the purpose of enabling TB Control to carry out a screening program; and is collected under the authority of British Columbia's Health Act.

Questions about the use and collection of this information can be directed to: Director, Division of TB Control, 655 West 12th Ave., Vancouver, B.C., V5Z 4R4. (604) 660-6102

## Instructions for Completing Form

**Part 2: Nurse completes**

Reason For Exam: **Population at risk screening**

01 LCCF, Resident
02 LCCF, Adult Care Employee
03 LCCF, Child Care Employee
04 Extended Care Hospital Resident
05 Health Centre Employee (Hospital)
06 Public Service Employee
07 School Board Employee
08 Correctional Centre Resident
09 Private Home Care Centre Support Ser.
10 Preschool, Parent/Volunteer
11 Volunteer (not Preschool)
13 Detox

**General Screening**

20 Ophthalmology Referral
22 Doctor's Referral
23 Immigration
24 Self -Referral, Symptoms
25 Self-Referral, Healthy
26 Other_____
27 Student
30 Employment, Other
38 Aboriginal School Survey
39 Aboriginal Canadian Survey

Patients with a tuberculin **10mm or >** should be referred for x-ray
Patients with a tuberculin **5mm or >** who are contacts or immunosuppressed should be referred for x-ray
Patients with a history of TB or a previously positive tuberculin should be referred for x-ray

If client is a TB contact and first TBN is negative indicate recommendation and send yellow copy to TB Control.

**Part 3: Nurse completes**

N.B. If x-ray required put client name in x-ray section above.
Do not separate but fold, staple, and instruct client to take form with them when they go for the x-ray.
Utilize a bring forward system to ensure x-ray has been taken and results have been received.

**Part 4: Division of TB control Physician completes**

If # 1 (no further testing) send yellow and pink copies to RHB/CHC/CHSS who will forward pink copy to client.
If # 2 send pink copy back to RHB/CHC/CHSS to arrange for a repeat x-ray
If # 3 send HLTH 840 Chest Consultation to client's physician and RHB/CHC/CHSS who will consult with the physician re notifying the client of results.

For detailed instructions see B.C. Ministry of Health, Preventive Services Policy Manual Vol 11.
For assistance consult the Division of TB Control (604) 660-6108 or your local Health Unit.