BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

TB Services for Aboriginal Communities

FAX #: 604-707-2690

TUBERCULIN MONTHLY REPORT

☐ **Nil Report**

The personal information collected on this form is used for the purpose of enabling TB Services for Aboriginal Communities to carry out a TB screening program and is collected under the authority of Bill 23 - Public Health Act of BC and kept confidential. Questions about the use and collection of this information should be directed to: TB Control, 655 W. 12th Ave. Vancouver BC, V5Z 4R4 Phone: 604-707-2695.

MONTH	YEAR	HEALTH CENTRE NAME & CODE									COMMUNITY		
NAME/ALIAS	DOB YY/MM/DD	M/F	ON/ OFF*	RFE**	DATE GIVEN YY/MM/DD	HCW	DATE READ YY/MM/DD	HCW	RESULT IN MM***	BCG SCAR Y/N	Hx TB Exposure? Y/N, Details	Symptom Check? Y/N	CXR Needed? Y/N

*** ON OR OFF RESERVE:**

1. Registered On-Reserve
2. Registered Off-Reserve
3. Non-Registered On-Reserve
4. Non-Registered Off-Reserve
5. Métis
6. Inuit
7. Non-Status

****REASON FOR EXAM (RFE):**

38 Aboriginal School Survey
39 Aboriginal Canadian Survey
13 Detox or Treatment
27 Student
30 Employment
22 Doctors referral
24 Self referral (symptoms)
25 Self referral (healthy)
26 Other, please specify

*** **NOTE ON RESULT:**

- TST ≥ 5mm in those who are immunosuppressed (ie. HIV) or contacts require a chest x-ray.
- All others with a 10mm or greater TST result should be chest x-rayed with or without symptoms.
- Those with symptoms should be chest x-rayed irrespective of TST results.
- Complete HLTH 939 Form and give to patient to present to Radiology.

HEALTH CARE WORKER (HCW)

Name: _____ Initials: _____

Name: _____ Initials: _____