BC Centre for Disease Control
An agency of the Provincial Health Services Authority

TB SCREENING FORM

☐ BILL TO TB SERVICES ☐ PAYMENT RECEIVED MSP BILLING # 99996

TODAY'S DATE (YYYY/MM/DD)	PERSONAL HEALTH NUMBER (PHN)	TB SERVICES USE ONLY
		ID NUMBER

PART 1: CLIENT COMPLETES (use ink and print clearly)

NAME (Last / First / Middle)	ALTERNATE NAME	DATE OF BIRTH (YYYY/MM/DD)

FULL ADDRESS	CITY	PROVINCE	POSTAL CODE

GENDER
☐ FEMALE ☐ MALE ☐ X
GENDER IDENTITY
☐ FEMALE ☐ MALE ☐ NON-BINARY ☐ TRANSGENDER ☐ TWO-SPIRIT
☐ UNSURE/QUESTIONING ☐ PREFER NOT TO ANSWER
☐ MY GENDER IS _____

RESIDE IN FIRST NATIONS COMMUNITY
☐ NO ☐ YES (50% of time or more) _____ (COMMUNITY NAME)
SELF-IDENTIFICATION AS AN INDIGENOUS PERSON OF CANADA
☐ YES, CHECK ALL THAT APPLY: ☐ FIRST NATIONS, ☐ STATUS ☐ NON-STATUS ☐ INUIT ☐ MÉTIS
☐ NO ☐ PREFER NOT TO ANSWER

COUNTRY OR CANADIAN PROVINCE OF BIRTH	DATE ENTERED CANADA (YYYY/MM/DD)	PRIMARY PHONE NUMBER	ALTERNATE PHONE NUMBER

NAME OF REFERRING HEALTH CARE PROVIDER (HCP) & SPECIALTY	PHONE NUMBER OF REFERRING HCP
NAME OF PRIMARY HCP & ADDRESS	PHONE NUMBER OF PRIMARY HCP

PART 2: HEALTH CARE PROVIDER COMPLETES

REASON FOR SCREENING	MEDICATION ☐ YES (SPECIFY) ☐ NO ALLERGIES REACTION	LIVE VACCINE ADMINISTRATION WITHIN THE LAST 4 WEEKS?
Choose from dropdown menu		☐ YES ☐ NO

IF CONTACT, NAME OF TB CASE OR ID#	LAST DATE OF CONTACT (YYYY/MM/DD)	HISTORIC EXPOSURE IF KNOWN? IF YES, LIST DETAILS (NAME, DATE, ID#)
		☐ YES ☐ NO

RISK FACTORS
☐ **NONE**
☐ HIV ☐ TRANSPLANT (SPECIFY)_____ ☐ DIABETES
☐ CHRONIC KIDNEY DISEASE/DIALYSIS ☐ CANCER (SPECIFY)_____
☐ IMMUNE SUPPRESSING MEDS _____ (SPECIFY NAME, DOSE & DURATION)
☐ SUBSTANCE USE Choose from the dropdown
☐ SETTING Choose from the dropdown mer
☐ TRAVEL (SPECIFY, REFER TO BACK):
☐ OTHER (SPECIFY):

SYMPTOMS
☐ **NONE** ☐ CHEST PAIN ☐ COUGH ☐ FATIGUE ☐ FEVER ☐ HAEMOPTYSIS ☐ LYMPHADENOPATHY
☐ NIGHT SWEATS ☐ SHORT OF BREATH ☐ SPUTUM PRODUCTION ☐ WEIGHT LOSS ☐ OTHER _____

SPUTUM FOR AFB COLLECTED
☐ YES, # COLLECTED _____
☐ NO

ADDITIONAL COMMENTS:

HEPATITIS HISTORY?	PREVIOUS BCG?	BCG SCAR?
☐ **NONE** ☐ HEP B ☐ HEP C ☐ UNKNOWN	☐ YES, DATE (YYYY/MM/DD) _____ ☐ NO ☐ UNKNOWN	☐ YES ☐ NO ☐ UNKNOWN

HAS CLIENT EVER HAD TB?	TREATMENT?	RESULT OF PREVIOUS TST
☐ ACTIVE ☐ LATENT ☐ NO	☐ YES ☐ NO	LOCATION _____ DATE (YYYY/MM/DD) _____ ☐ NEGATIVE ☐ POSITIVE ☐ UNKNOWN

INITIAL TST ☐ **DECLINED** ☐ **INFORMED CONSENT**
GIVEN BY(*PLEASE PRINT*):_____
HA/HSDA/BRANCH/FACILITY: _____
LOT # _____

☐ **DID NOT TEST (SPECIFY)**

DATE GIVEN (YYYY/MM/DD)	DATE READ (YYYY/MM/DD)	SIZE OF INDURATION	READ BY (PLEASE PRINT)
TIME GIVEN:	TIME READ:	MM	☐ NEGATIVE ☐ POSITIVE

FOLLOW-UP BASED ON ABOVE TB ASSESSMENT
☐ NO FURTHER TESTING ☐ REPEAT TST AS REQUIRED IN _____ WEEKS ☐ IGRA CONSULT ☐ RECOMMEND CHEST X-RAY _____ LOCATION ☐ SPUTUM

REPEAT TST ☐ **DECLINED** ☐ **INFORMED CONSENT**
GIVEN BY(*PLEASE PRINT*):_____
HA/HSDA/BRANCH/FACILITY: _____
LOT # _____

☐ **DID NOT TEST (SPECIFY)**

DATE GIVEN (YYYY/MM/DD)	DATE READ (YYYY/MM/DD)	SIZE OF INDURATION	READ BY (PLEASE PRINT)
TIME GIVEN:	TIME READ:	MM	☐ NEGATIVE ☐ POSITIVE

FOLLOW-UP BASED ON ABOVE TB ASSESSMENT
☐ NO FURTHER TESTING ☐ SPUTUM FOR AFB ☐ RECOMMEND CHEST X-RAY LOCATION

REASON FOR NOT HAVING CHEST X-RAY
☐ REFUSED ☐ OTHER (SPECIFY):

HISTORY OF IGRA TEST?	RESULT OF PREVIOUS IGRA
☐ YES, TYPE: ☐ QFT ☐ T-SPOT ☐ NO	LOCATION _____ DATE (YYYY/MM/DD)_____ ☐ NON-REACTIVE ☐ REACTIVE ☐ UNKNOWN

PART 3: RADIOLOGY COMPLETES

CHEST X-RAY RESULT
☐ NORMAL ☐ ABNORMAL ☐ OUTSIDE REPORT ONLY

COMMENTS

RADIOLOGIST'S SIGNATURE	DATE SIGNED (YYYY/MM/DD)

PART 4: TB SERVICES COMPLETES

X-RAY NUMBER	X-RAY DATE (YYYY/MM/DD)

RECOMMENDATIONS
☐ NO EVIDENCE OF ACTIVE TB ☐ CLINIC APPOINTMENT ☐ NO EVIDENCE LTBI
☐ SEE PHYSICIAN'S REPORT ☐ STANDARD LETTER #_____ ☐ CLEARED FOR BIOLOGICS
☐ IGRA ☐ TB CONTACT: REPEAT CXR IN ____ MTHS

SIGNATURE	DATE SIGNED (YYYY/MM/DD)

REVISED 2019/05

INSTRUCTIONS FOR COMPLETING FORM

PART 2: HEALTH CARE PROVIDER COMPLETES

Reason for Screening:

01 Doctor's Referral
- a. Symptomatic
- b. Abnormal Imaging
- c. Ophthalmology
- d. Pre-biologic
- e. Provincial Renal TB Screening
- f. Other

02 Contact*
- a. High priority
- b. Medium priority
- c. Low Priority

03 School

04 Employment
- a. LCCF, Adult Care Employee
- b. LCCF, Child Care Employee
- c. Health Authority Employee
- d. Health Authority Employee (Non-Hospital)
- e. Public Service Employee
- f. School Board Employee
- g. Private Home Care Centre Support Services
- h. Other

05 Facility Resident
- a. Extended Care
- b. Adult Residential Care (<60yrs)
- c. Other

06 Detox OR Drug and Alcohol Treatment

07 Corrections Facility

08 Immigration

09 Volunteer
- a. Preschool
- b. All others

10 Self-Referral
- a. Symptoms
- b. Healthy

11 BC First Nations TB Services

12 Other

***CONTACT PRIORITY**

High: household contacts plus close non-household contacts who are high risk**

Medium: close non-household contacts with daily or almost daily exposure, including those at school and work

Low: casual contacts with lower amounts of exposure

****High Risk**: Child under 5, HIV+, transplant recipient on immune suppressing treatment; and other conditions in consultation with TB Services, such as people with chronic kidney disease on dialysis and/or end-stage; people taking or about to start chemotherapy or TNF-alpha inhibitors or systemic corticosteroids (equivalent to ≥ 15mg/day of prednisone for 2 weeks or longer).

RISK FACTORS

SUBSTANCE USE: Specify on page 1 if: Alcohol (>3 drinks/day); Injection Drug Use; Tobacco Use; Other

SETTING: Specify on page 1 if: School/University; Childcare Worker; Contact with person with active TB in past 2 years; Correctional facility; Health Care Worker; Homelessness/Underhoused (past or current); Group living

TRAVEL: 3+ months to high TB incidence area in the last 2 years

REFERRAL TO TB SERVICES

Fax the 1st page of this form when a client:

- Is symptomatic
- Has a positive TST (individuals **10mm or greater**, contacts & immune-compromised **5mm or greater**)
- Requires a CXR
- Is a recent contact to TB (within the last two years) and is high risk**

Please instruct client to take this form with them when they go for chest x-ray.

For assistance consult BCCDC TB Services **604.707.5678** or your local Health Unit.

EXTERNAL RADIOLOGY DEPARTMENT – X-RAY RESULTS

NORMAL OR ABNORMAL: Send/fax reports to TB Services

Note: Please copy all reports to Referring Physician/Health Care Provider (see Part 1)

BCCDC Provincial TB Services
655 West 12th Avenue
Vancouver BC V5Z 4R4
Fax: 604.707.2690

Island TB Services
Royal Jubilee Hospital, Royal Block, 4th Floor
1952 Bay Street
Victoria, BC V8R 1J8
Fax: 250.519.1505

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PART 2: HEALTH CARE PROVIDER COMPLETES

REASON FOR SCREENING
Refer to Codes
Choose from dropdown menu

MEDICATION ☐ YES (SPECIFY) ☐ NO
ALLERGIES REACTION

LIVE VACCINE ADMINISTRATION WITHIN THE LAST 4 WEEKS?
☐ YES ☐ NO

LAST DATE OF CONTACT (YYYY/MM/DD)

HISTORIC EXPOSURE IF KNOWN? IF YES, LIST DETAILS (NAME, DATE, ID#)
☐ YES
☐ NO

SYMPTOMS
☐ **NONE** ☐ CHEST PAIN ☐ COUGH ☐ FATIGUE ☐ FEVER ☐ HAEMOPTYSIS ☐ LYMPHADENOPATHY
☐ NIGHT SWEATS ☐ SHORT OF BREATH ☐ SPUTUM PRODUCTION ☐ WEIGHT LOSS ☐ OTHER _____

SPUTUM FOR AFB COLLECTED?
☐ YES, # COLLECTED _____
☐ NO

PREVIOUS BCG?
☐ YES, DATE (YYYY/MM/DD) _____ ☐ NO ☐ UNKNOWN

BCG SCAR?
☐ YES ☐ NO ☐ UNKNOWN

HAS CLIENT EVER HAD TB?
☐ ACTIVE ☐ LATENT ☐ NO

TREATMENT?
☐ YES ☐ NO

RESULT OF PREVIOUS TST
LOCATION _____ DATE (YYYY/MM/DD) _____ ☐ NEGATIVE ☐ POSITIVE ☐ UNKNOWN

INITIAL TST ☐ **DECLINED** ☐ **INFORMED CONSENT**
GIVEN BY *(PLEASE PRINT)*: _____
HA/HSDA/BRANCH/FACILITY: _____
LOT # _____

☐ **DID NOT TEST** (SPECIFY) _____

DATE GIVEN (YYYY/MM/DD)	DATE READ (YYYY/MM/DD)	SIZE OF INDURATION	READ BY (PLEASE PRINT)
TIME GIVEN:	TIME READ:	MM	☐ NEGATIVE ☐ POSITIVE

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CHEST X-RAY RESULT
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COMMENTS

RADIOLOGIST'S SIGNATURE | DATE SIGNED (YYYY/MM/DD)

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X-RAY NUMBER	X-RAY DATE (YYYY/MM/DD)

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☐ IGRA ☐ TB CONTACT: REPEAT CXR IN ____ MTHS

SIGNATURE | DATE SIGNED (YYYY/MM/DD)

This page is to be used as a chest x-ray requisition

REVISED 2019/05