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

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	☐ ID CHECKED	☐ MAIL ☐ PICKUP

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

LAST NAME	GIVEN NAME(S)	MAIDEN NAME (IF APPLICABLE)

FULL ADDRESS	CITY	PROVINCE	POSTAL CODE

DATE OF BIRTH (YYYY/MM/DD)	GENDER ☐ M ☐ F	ETHNIC ORIGIN	FIRST NATIONS STATUS ☐ STATUS INDIAN ☐ NON-STATUS INDIAN	☐ FIRST NATIONS ☐ INUIT ☐ MÉTIS	FIRST NATIONS COMMUNITY ☐ ON RESERVE ☐ OFF RESERVE

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

NAME OF REFERRING PHYSICIAN(S)/HEALTH CARE PROVIDER (HCP) & SPECIALTY	PHONE NUMBER OF REFERRING HCP
NAME OF FAMILY GP	PHONE NUMBER OF FAMILY GP

PART 2: HEALTH CARE PROVIDER COMPLETES

REASON FOR SCREENING (REFER TO CODES) _____ Choose reason from dropdown below	MEDICATION ALLERGIES ☐ **NONE** ☐ YES _____ _____ REACTION	RECENT LIVE VACCINE ADMINISTRATION? ☐ **NONE** ☐ YES DATE (YYYY/MM/DD) _____

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) _____ ☐ CHRONIC RENAL DISEASE/DIALYSIS ☐ CANCER (SPECIFY) _____ ☐ DIABETES
☐ TRAVEL TO HIGH PREVALENCE COUNTRY (SPECIFY WHERE & DATES) _____ ☐ SUBSTANCE USE _____ ☐ HOMELESSNESS/UNDERHOUSED
☐ IMMUNE SUPPRESSING MEDS (SPECIFY NAME, DOSE & DURATION) _____ ☐ OTHER (SPECIFY) _____

SYMPTOMS
☐ **NONE** ☐ COUGH ☐ PRODUCTIVE COUGH ☐ HAEMOPTYSIS ☐ NIGHT SWEATS ☐ FEVER ☐ WEIGHT LOSS ☐ CHEST PAIN
☐ FATIGUE ☐ LYMPHADENOPATHY ☐ OTHER _____

SPUTUM FOR AFB COLLECTED? ☐ YES ☐ NO ☐ NUMBER COLLECTED _____

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

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

INITIAL TST ☐ **DECLINED** ☐ **DID NOT TEST** _____

GIVEN BY *(ENTER CODE OF HA/HSDA/BRANCH, HOSPITAL, HEALTH CENTRE AND PRINT PROVIDER NAME)*

DATE GIVEN (YYYY/MM/DD)	DATE READ (YYYY/MM/DD)	SIZE OF INDURATION MM	READ BY ☐ negative ☐ positive

LOT # _____

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** ☐ **DID NOT TEST** _____

GIVEN BY *(ENTER CODE OF HA/HSDA/BRANCH, HOSPITAL, HEALTH CENTRE AND PRINT PROVIDER NAME)*

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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? ☐ NO ☐ QFT ☐ T-SPOT	RESULT OF IGRA? ☐ NON-REACTIVE ☐ REACTIVE ☐ UNKNOWN	DATE (YYYY/MM/DD)	LOCATION

ADDITIONAL COMMENTS:

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	XRAY DATE (YYYY/MM/DD)

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

SIGNATURE	DATE SIGNED (YYYY/MM/DD)

REVISED 2015/06

INSTRUCTIONS FOR COMPLETING FORM

PART 2: HEALTH CARE PROVIDER COMPLETES

Reason for Assessment:

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 (Hospital)
- d. Health Authority Employee (Non-Hospital)
- e. Public Service Employee
- f. School Board Employee
- g. Private Home Care Centre Support Serv.
- h. Other

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

06 Detox/Drug & Alcohol Treatment

07 Correctional Facility

08 Immigration

09 Volunteer
- a. Preschool
- b. All other except preschool

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

11 TB Services for Aboriginal Communities (TBSAC)

12 Other _____

Contact Priority

High: household contacts plus close non-household contacts who are immunologically vulnerable
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: any individual who is immune-compromised, HIV+, child under 5

Refer care to TB Services by faxing 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) is immune compromised, HIV positive or a child under 5.

Please instruct client to take 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: Send/fax reports to TB Services

ABNORMAL: Send/fax report to TB Services. TB Services will contact facility and request image if not received.

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

BCCDC Provincial TB Services
655 West 12th Avenue
Vancouver BC V5Z4R4
Fax: 604.707.2690

Island TB Services
Royal Jubilee Hospital
Royal Block, 4th Floor
1952 Bay Street
Victoria BC V8R1J8
Fax: 250.519.1505

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

SYMPTOMS
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SIGNATURE	DATE SIGNED (YYYY/MM/DD)

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

REVISED 2015/06