TB Screening - Downtime Form

Personal Details

Last Name: **First Name:** **Client ID:**

DOB (yyyy/mm/dd): / / **Gender:** M / F **Health Care No:**

Address: **Phone No:**

Postcode:

Aboriginal Information

Does Client Wish to Self-Identify? **Aboriginal Identity (if applicable):**

First Nations Status (if applicable):

Aboriginal Organization (if applicable):

Immigration Information

Canadian Citizen? **Arrival Date (if applicable):** / /

Country Emigrated From (if applicable): **Country Born In:**

Create Investigation

Classification: **Classification Date (yyyy/mm/dd):** / /

External Sources

Family Physician: **Phone No:**

Effective From Date (yyyy/mm/dd): / /

Specialist: **Phone No:**

Effective From Date (yyyy/mm/dd): / /

Allergies

☐ **No Known Allergies** ☐ **Allergy (if yes, see allergy fields below)**

Allergy Category: **Allergy Type:**

Allergy SubType **Reaction:**

Date Reported (yyyy/mm/dd): / / **Effective From (yyyy/mm/dd):** / /

Onset Date (if known) (yyyy/mm/dd): / / **Source of Information:**

Risk Factors

Chronic Medical Condition:

- ☐ Diabetes Mellitus
- ☐ Kidney Disease not requiring dialysis
- ☐ Kidney Disease requiring dialysis
- ☐ Kidney Disease dialysis unknown
- ☐ Liver Disease-Hepatitis B
- ☐ Liver Disease-Hepatitis C
- ☐ Liver Disease-Other- Specify
- ☐ Malignancies/Cancer
- ☐ Underweight

Exposure Risk

- ☐ Housing-Homelessness/Underhoused
- ☐ Housing - Correctional Facility
- ☐ Travel for 3+ Months to High TB Prevalence Country
- ☐ Group Living Setting (Specify)

Immunocompromised

- ☐ HIV
- ☐ Transplant Candidate or Recipient-Solid Organ/Tissue
- ☐ Other-Specify
- ☐ Congenital Aquired Immunodeficiency
- ☐ Treatment - Specify

Substance Use

- ☐ Substance Use-Other (Specify)
- ☐ Substance Use - Tobacco

Additional Information-Risk Factors:

Signs & Symptoms

- ☐ Chest Pain
- ☐ Cough
- ☐ Fatigue
- ☐ Fever
- ☐ Haemoptosis
- ☐ Lymphadenopathy (enlarged glands)
- ☐ Night Sweats
- ☐ Shortness of breath/breathing difficulty
- ☐ Sputum production
- ☐ Weight Loss

Additional Information-Signs/Symptoms:

Consent Directives (TB Skin Test)

Consent: Grant ○ ***or*** **Refuse** ○

Consent Given By: _____ **Form of Consent:** _____

Consent Given To: _____ **Effective From Date (yyyy/mm/dd):** ____ / ____ / ____

TB Test Details

Clinical Information (***This*** *subsection pertains to previous contact,* ***not*** *current exposure*)

Other TB Case Contact:

☐ No ☐ Unknown ☐ Yes

Other Exposure Date:

○ **Full Date (yyyy/mm/dd):** ____ / ____ / ____ ○ **Partial Date (yyyy/mm/dd):** ____ / ____

Recent Illness:

☐ No ☐ Unknown ☐ Yes

Recent Illness Date:

○ **Full Date (yyyy/mm/dd):** ____ / ____ / ____ ○ **Partial Date (yyyy/mm/dd):** ____ / ____

Clinical Comments:

panorama

Test Given Details

Reason for Test:

☐ **Historical**

Doctors Referral:

☐ **Symptomatic**
☐ **Abnormal Imaging**
☐ **Opthalmology**
☐ **Pre-Biologic**
☐ **Renal TB Screening**
☐ **Other**

Contact:

☐ **High Priority**
☐ **Medium Priority**
☐ **Low Priority**

Employment:

☐ **LCCF, Adult Care Employee**
☐ **LCCF, Child Care Employment**
☐ **Health Authority (hospital)**
☐ **Health Authority (non hospital)**
☐ **Public Service Employee**
☐ **Private Home Care Centre**
☐ **Other**

Facility Resident:

☐ **Extended Care**
☐ **Adult Residential Care (<60 yrs)**
☐ **Other**

Volunteer:

☐ **Preschool**
☐ **All other, except preschool**

Self Referral:

☐ **Healthy**
☐ **Symptoms**

Other Reasons for Test:

☐ **Immigration**
☐ **Correctional Facility**
☐ **Detox/Drug & Alcohol Facility**
☐ **School**
☐ **Other, see clinical comments**
☐ **TB Services for Aboriginal Communities**

SDL **(Location):**

Given by Provider:

Date Test Given: (**yyyy/mm/dd**): ____ / ____ / ____

TB Serum Agent: **Lot #:** **Dose:**

Body Site:

○ **Forearm-Left** ○ **Forearm-Right** ○ **Other**

Test Read Details

Date Test Read: (**yyyy/mm/dd**): ____ / ____ / ____

Location: Provider:

Interpreted Result:

☐ **Blister (positive)**
☐ **Hypersensitivity (negative)**
☐ **Negative**
☐ **Not Read**
☐ **Positive**
☐ **Unknown**

Reaction Size: **mm**

TB Follow-Up

Follow-Up Date (**yyyy/mm/dd**): ____ / ____ / ____

SDL (location): Provider:

Follow Up:

☐ **IGRA**
☐ **No Follow Up Required**
☐ **Recommend X-Ray**
☐ **Sputum**
☐ **Repeat Skin Test - see follow up details**

Reason for Not Having Chest X-Ray:

☐ **Other**
☐ **Pregnant**
☐ **Refused**

Follow-Up Details:

TB History Summary

Previous TB Test:
- ☐ **Negative**
- ☐ **Positive**
- ☐ **None**
- ☐ **Unknown**

Source:
- ☐ **Client**
- ☐ **Other**

Previous Test Date:
- ○ **Full Date** (**yyyy/mm/dd**): ____ / ____ / ____
- ○ **Partial Date** (**yyyy/mmd**): ____ / ____

Previous Test Country: _____

Previous Diagnosis:
- ☐ **Active TB**
- ☐ **None**
- ☐ **Latent TB**
- ☐ **Unknown**

Previous Diagnosis Date:
- ○ **Full Date:** (**yyyy/mm/dd**): ____ / ____ / ____
- ○ **Partial Date:** (**yyyy/mm**): ____ / ____

Previous Treatment**:**
- ☐ **Active TB**
- ☐ **Prophylaxis**
- ☐ **Untreated**
- ☐ **None**
- ☐ **Unknown Treatment**

Previous Treatment Date:
- ○ **Full Date:** (**yyyy/mm/dd**): ____ / ____ / ____
- ○ **Partial Date** (**yyyy/mm**): ____ / ____

Previous BCG Vaccine:
- ☐ **No**
- ☐ **Unknown**
- ☐ **Yes**

BCG Vaccine Date:
- ○ **Full Date** (**yyyy/mm/dd**): ____ / ____ / ____
- ○ **Partial Date** (**yyyy/mm**): ____ / ____

BCG Vaccine Country**:** _____

BCG Scar Visible:
- ☐ **No**
- ☐ **Unknown**
- ☐ **Yes**

Client Age at Last BCG: _____ **Years**

TB History Comments: