BC Centre for Disease Control
Provincial Health Services Authority

TB SCREENING FORM

Provincial Tuberculosis Services

BILLING INSTRUCTIONS: ☐ PAYMENT RECEIVED ☐ BILL CLIENT ☐ BILL MSP ☐ BILL TB SERVICES 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 ON BC SERVICES CARD Last / First / Middle	NAME (PREFERRED)	DATE OF BIRTH (YYYY/MM/DD)
FULL ADDRESS	CITY / PROVINCE	POSTAL CODE

WHAT SEX IS ON YOUR BC SERVICE CARD?
☐ FEMALE ☐ MALE ☐ X ☐ PREFER NOT TO ANSWER

TO SELF-IDENTIFY YOUR GENDER AND PRONOUNS, PLEASE COMPLETE THE FOLLOWING
☐ PREFER NOT TO ANSWER ☐ FEMALE ☐ MALE ☐ AGENDER
☐ NON-BINARY ☐ TRANSGENDER ☐ GENDER CREATIVE
☐ MY GENDER IS ______________________________

☐ MY PRONOUNS ARE ______________________________

DO YOU SELF-IDENTIFY AS AN INDIGENOUS PERSON? ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

IF YES, HOW DO YOU IDENTIFY? SELECT ALL THAT APPLY ☐ FIRST NATIONS, ☐ STATUS ☐ NON-STATUS ☐ INUIT ☐ MÉTIS

DO YOU RESIDE IN A FIRST NATIONS COMMUNITY? ☐ YES (50% OF TIME OR MORE) ☐ NO

IF YES, WHICH COMMUNITY DO YOU LIVE IN? ______________________________

DO YOU IDENTIFY AS TWO-SPIRIT? ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

COUNTRY OR CANADIAN PROVINCE OF BIRTH	DATE ENTERED CANADA (YYYY/MM/DD)	PRIMARY PHONE NUMBER	CELL PHONE NUMBER
NAME & SPECIALTY OF REFERRING PROVIDER	PHONE NUMBER	NAME & ADDRESS OF PRIMARY CARE PROVIDER	PHONE NUMBER

PART 2: HEALTH CARE PROVIDER COMPLETES

REASON FOR SCREENING (SEE CODES ON PAGE 2)

ALLERGIES ☐ NO ☐ YES, LIST ITEM AND REACTION

INJECTABLE LIVE VIRUS VACCINE OR MAJOR VIRAL ILLNESS IN THE LAST 4 WEEKS ☐ YES, DATE ☐ NO

IF CONTACT, NAME OF TB CASE OR ID#

LAST DATE OF CONTACT

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

TB RISK FACTORS
☐ NONE ☐ HIV ☐ TRANSPLANT TYPE ______________________
☐ DIABETES ☐ CHRONIC KIDNEY DISEASE/DIALYSIS
☐ CANCER TYPE ______________________
☐ IMMUNE SUPPRESSING MEDS (INCLUDE NAME, DOSE & DURATION)

SEE DEFINITIONS ON PAGE 2
☐ SUBSTANCE USE ______________________
☐ SETTING ______________________
☐ TRAVEL ______________________
☐ OTHER ______________________

TB TREATMENT RISK FACTOR
HEPATITIS HISTORY
☐ NONE ☐ HEP B ☐ HEP C
☐ UNKNOWN

TB SYMPTOMS
☐ NONE ☐ CHEST PAIN ☐ COUGH > 3 WEEKS ☐ EXTREME FATIGUE ☐ FEVER ☐ BLOOD IN SPUTUM ☐ LYMPHADENOPATHY ☐ DRENCHING NIGHT SWEATS
☐ SHORT OF BREATH ☐ SPUTUM PRODUCTION ☐ UNEXPLAINED WEIGHT LOSS ______ KG IN _____ MONTHS ☐ OTHER ______________________

ADDITIONAL COMMENTS / DESCRIPTION OR CHANGE OF SYMPTOMS (E.g. new or worsening, onset, duration) / RISK FACTOR DETAILS

PREVIOUS BCG ☐ YES, DATE ☐ NO ☐ UNKNOWN

BCG SCAR ☐ YES ☐ NO ☐ UNKNOWN

HISTORY OF ACTIVE TB OR LTBI ☐ ACTIVE ☐ LATENT ☐ NO

TREATMENT ☐ YES, DATE ☐ NO

HISTORY OF TST ☐ NO ☐ YES, LOCATION/DATE — RESULT OF PREVIOUS TST ☐ NEGATIVE ☐ POSITIVE ☐ UNKNOWN

HISTORY OF IGRA ☐ NO ☐ YES, TYPE ☐ QFT ☐ T-SPOT LOCATION/DATE — RESULT OF PREVIOUS IGRA ☐ NON-REACTIVE ☐ REACTIVE ☐ UNKNOWN

INITIAL TST ☐ INFORMED CONSENT
SITE OF TST PLANT ______________________
GIVEN BY (PRINT) ______________________
HA & FACILITY ______________________
LOT # ____________

☐ DID NOT TEST (REASON) ______________________

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

FOLLOW-UP RECOMMENDATIONS
☐ NO FURTHER TESTING ☐ REPEAT TST IN _____ WEEKS ☐ SPUTUM FOR AFB ☐ IGRA ☐ CXR, TYPE ☐ POSTERIOR-ANTERIOR (PA) ☐ LATERAL ☐ DECLINED__________

REPEAT TST ☐ INFORMED CONSENT
SITE OF TST PLANT ______________________
GIVEN BY (PRINT) ______________________
HA & FACILITY ______________________
LOT # ____________

☐ DID NOT TEST (REASON) ______________________

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

FOLLOW-UP RECOMMENDATIONS
☐ NO FURTHER TESTING ☐ SPUTUM FOR AFB ☐ CXR, TYPE ☐ PA ☐ LATERAL ☐ DECLINED______________

PART 3: TB SERVICES COMPLETES - RADIOLOGY RESULTS

LOCATION OF CXR ______________________ DATE OF CXR ______________________ CXR ON ☐ CARECONNECT ☐ E-FILM ☐ SECURE DRIVE ☐ WCMI OR ☐ REPORT ONLY

PART 4: TB SERVICES COMPLETES - RECOMMENDATIONS

☐ NO EVIDENCE OF ACTIVE TB
☐ SEE REPORT
☐ TB LETTER (SPECIFY) ______________________

☐ REPEAT TST
☐ IGRA

CLINIC APPOINTMENT
☐ LTBI OFFER
☐ OTHER (SPECIFY) ______________________

DATE & SIGNATURE

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INSTRUCTIONS FOR COMPLETING THE TB SCREENING FORM

BILLING INSTRUCTIONS

Bill MSP, but, if MSP is not active, bill the client unless testing is being done to investigate active TB disease, then bill TB Services.

REASON FOR SCREENING CODES (see definitions below)

01- Doctor Referral a. Symptomatic b. Abnormal Imaging c. Ophthalmology d. Pre-Biologic e. Provincial Renal TB Screening f. Other	**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	**06- Detox or Drug & Alcohol Treatment** **07- Corrections Facility** **08- Immigration** **09- Volunteer** a. Preschool b. All Others
02- Contact* a. High Priority b. Medium Priority c. Low Priority		**10- Self-Referral** a. Symptoms b. Healthy
03- School	**05- Facility Resident** a. Extended Care b. Adult Residential Care (< 60yrs) c. Other	**11- BC First Nations TB Services** **12- Other**

***CONTACT PRIORITY DEFINITIONS**

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 priority** includes children under five, people living with HIV, transplant recipients 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 two weeks or longer).

RISK FACTOR DEFINITIONS (specify on page one)

SUBSTANCE USE: Alcohol (> 3 drinks/day); Injection Drug Use; Tobacco Use; Other
SETTING: School/University; Childcare Worker; Contact with person with active TB in past two years; Correctional facility; Health Care Worker; **Homelessness/Underhoused^;** Group living
TRAVEL: 3+ months to high TB incidence area (cumulative in one's lifetime) or since last negative TST

^ **Homelessness/Underhoused** is defined as any shelter stay; no fixed address; any stay in a Single Room Occupancy (SRO) hotel or supportive housing including Temporary Modular Housing, or use of services for homeless persons more than once per week (e.g., soup kitchen, drop in centre, homeless outreach worker or program) since the client's last negative TST or in their lifetime in the absence of TST history.

CXR REQUISITION

Please use the **confidential page** of this form for the client's chest x-ray requisition.

REFERRAL PROCESS

For: BCCDC Provincial TB Services - Fax (604) 707-2690 OR Island TB Services - Fax (250) 519-1505

Fax **page one** of the 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****

For: FNHA TB Program - Fax (604) 689-3302

Fax **page one** of the form for **ANY client screened for TB in a First Nations community to the FNHA TB Program.**

BC Centre for Disease Control
Provincial Health Services Authority

TB SCREENING FORM

Provincial Tuberculosis Services
CONFIDENTIAL form for chest x-ray requisition

BILLING INSTRUCTIONS: ☐ PAYMENT RECEIVED ☐ BILL CLIENT ☐ BILL MSP ☐ BILL TB SERVICES 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 ON BC SERVICES CARD Last / First / Middle	NAME (PREFERRED)	DATE OF BIRTH (YYYY/MM/DD)
FULL ADDRESS	CITY / PROVINCE	POSTAL CODE

WHAT SEX IS ON YOUR BC SERVICE CARD?
☐ FEMALE ☐ MALE ☐ X ☐ PREFER NOT TO ANSWER

TO SELF-IDENTIFY YOUR GENDER AND PRONOUNS, PLEASE COMPLETE THE FOLLOWING
☐ PREFER NOT TO ANSWER ☐ FEMALE ☐ MALE ☐ AGENDER
☐ NON-BINARY ☐ TRANSGENDER ☐ GENDER CREATIVE
☐ MY GENDER IS ______________________________

☐ MY PRONOUNS ARE ___________________________

DO YOU SELF-IDENTIFY AS AN INDIGENOUS PERSON? ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

IF YES, HOW DO YOU IDENTIFY? SELECT ALL THAT APPLY ☐ FIRST NATIONS, ☐ STATUS ☐ NON-STATUS ☐ INUIT ☐ MÉTIS

DO YOU RESIDE IN A FIRST NATIONS COMMUNITY? ☐ YES (50% OF TIME OR MORE) ☐ NO

IF YES, WHICH COMMUNITY DO YOU LIVE IN? ______________________________

DO YOU IDENTIFY AS TWO-SPIRIT? ☐ YES ☐ NO ☐ PREFER NOT TO ANSWER

COUNTRY OR CANADIAN PROVINCE OF BIRTH	DATE ENTERED CANADA (YYYY/MM/DD)	PRIMARY PHONE NUMBER	CELL PHONE NUMBER
NAME & SPECIALTY OF REFERRING PROVIDER	PHONE NUMBER	NAME & ADDRESS OF PRIMARY CARE PROVIDER	PHONE NUMBER

PART 2: HEALTH CARE PROVIDER COMPLETES

REASON FOR SCREENING (SEE CODES ON PAGE 2)	ALLERGIES ☐ NO ☐ YES, LIST ITEM AND REACTION	INJECTABLE LIVE VIRUS VACCINE OR MAJOR VIRAL ILLNESS IN THE LAST 4 WEEKS ☐ YES, DATE ☐ NO
	LAST DATE OF CONTACT	HISTORIC EXPOSURE? IF YES, LIST DETAILS (NAME, DATE, ID#) ☐ YES ☐ NO

TB SYMPTOMS ☐ NONE ☐ CHEST PAIN ☐ COUGH > 3 WEEKS ☐ EXTREME FATIGUE ☐ FEVER ☐ BLOOD IN SPUTUM ☐ LYMPHADENOPATHY ☐ DRENCHING NIGHT SWEATS ☐ SHORT OF BREATH ☐ SPUTUM PRODUCTION ☐ UNEXPLAINED WEIGHT LOSS _______ KG IN _____ MONTHS ☐ OTHER ____________________

PREVIOUS BCG ☐ YES, DATE ☐ NO ☐ UNKNOWN	BCG SCAR ☐ YES ☐ NO ☐ UNKNOWN	HISTORY OF ACTIVE TB OR LTBI ☐ ACTIVE ☐ LATENT ☐ NO	TREATMENT ☐ YES, DATE ☐ NO

HISTORY OF TST ☐ NO ☐ YES, LOCATION/DATE RESULT OF PREVIOUS TST ☐ NEGATIVE ☐ POSITIVE ☐ UNKNOWN

HISTORY OF IGRA ☐ NO ☐ YES, TYPE ☐ QFT ☐ T-SPOT LOCATION/DATE RESULT OF PREVIOUS IGRA ☐ NON-REACTIVE ☐ REACTIVE ☐ UNKNOWN

INITIAL TST ☐ INFORMED CONSENT SITE OF TST PLANT ______________ GIVEN BY (PRINT) ______________ HA & FACILITY ______________ LOT # ________	☐ DID NOT TEST (REASON) ________ DATE GIVEN (YYYY/MM/DD) TIME GIVEN	DATE READ (YYYY/MM/DD) TIME READ	SIZE OF INDURATION MM	READ BY (PRINT) ☐ NEGATIVE ☐ POSITIVE

FOLLOW-UP RECOMMENDATIONS
☐ NO FURTHER TESTING ☐ REPEAT TST IN _____ WEEKS ☐ SPUTUM FOR AFB ☐ IGRA ☐ CXR, TYPE ☐ POSTERIOR-ANTERIOR (PA) ☐ LATERAL ☐ DECLINED__________

REPEAT TST ☐ INFORMED CONSENT SITE OF TST PLANT ______________ GIVEN BY (PRINT) ______________ HA & FACILITY ______________ LOT # ________	☐ DID NOT TEST (REASON) ________ DATE GIVEN (YYYY/MM/DD) TIME GIVEN	DATE READ (YYYY/MM/DD) TIME READ	SIZE OF INDURATION MM	READ BY (PRINT) ☐ NEGATIVE ☐ POSITIVE

FOLLOW-UP RECOMMENDATIONS
☐ NO FURTHER TESTING ☐ SPUTUM FOR AFB ☐ CXR, TYPE ☐ PA ☐ LATERAL ☐ DECLINED______________

PART 3: TB SERVICES COMPLETES - RADIOLOGY RESULTS

LOCATION OF CXR ____________________ DATE OF CXR ________________ CXR ON ☐ CARECONNECT ☐ E-FILM ☐ SECURE DRIVE ☐ WCMI OR ☐ REPORT ONLY

PART 4: TB SERVICES COMPLETES - RECOMMENDATIONS

☐ NO EVIDENCE OF ACTIVE TB ☐ SEE REPORT ☐ TB LETTER (SPECIFY) ______________	☐ REPEAT TST ☐ IGRA	CLINIC APPOINTMENT ☐ LTBI OFFER ☐ OTHER (SPECIFY) ______________	DATE & SIGNATURE

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INSTRUCTIONS FOR CHEST X-RAY REQUISITION

PATIENTS - This form is your chest x-ray requisition; please give this form to the radiology facility when getting your chest x-ray.

EXTERNAL RADIOLOGY DEPARTMENT

BILLING INSTRUCTIONS
Bill MSP, but, if MSP is not active, bill the client unless testing is being done to investigate active TB disease, then bill TB Services.

CHEST X-RAY RESULTS

1. Please send or fax all **NORMAL or ABNORMAL** results to TB Services.

   BCCDC Provincial TB Services
   655 West 12th Avenue
   Vancouver BC V5Z 4R4
   Fax (604) 707-2690

   OR

   Island TB Services
   Royal Jubilee Hospital, Royal Block, 4th Floor
   1952 Bay Street
   Victoria, BC V8R 1J8
   Fax (250) 519-1505

2. Please send copies of the chest x-ray report to **ALL Referring Health Care Providers in part one of this form.**