Yukon Communicable Disease Control – TB Control
4 Hospital Road, Whitehorse, YT Y1A 3H8
Phone: 667-8323 Fax: 667-8349

APPENDIX K
SAMPLE FORMS AND DOCUMENTS

APPENDIX K-1: Sample *Tuberculosis Screening Program* Form

APPENDIX K-2: Request for XRay

APPENDIX K-3: Client Notification Letter of LTBI Treatment Recommendation

APPENDIX K-4: BCCDC *Request for Preventative Therapy* Form

APPENDIX K-5: Directly Observed Therapy (DOT) Checklist

APPENDIX K-6: Sample *Airborne Precautions* Signage

APPENDIX K-1 (Page 1)

TUBERCULOSIS SCREENING PROGRAM

Originating Source ______________________________

PART 1

NURSE COMPLETES CLIENT INFO

Use black ballpoint and press hard

NAME (FAMILY NAME)	GIVEN NAME	MAIDEN NAME / AKA	DATE FORM INITIATED (yyyy/mm/dd)

ADDRESS No. and Street or P.O. Box	CITY/TOWN/MUNICIPALITY	PROVINCE/TERR.	POSTAL CODE

HOME PHONE NUMBER	WORK PHONE NUMBER	GENDER ☐ Male ☐ Female	ETHNIC ORIGIN	Y.H.I.S. #

DATE OF BIRTH (yyyy/mm/dd)	COUNTRY OR CANADIAN PROVINCE OF BIRTH	DATE ENTERED CANADA (yyyy/mm/dd)	ALLERGIES

PART 2

NURSE COMPLETES

REASON FOR EXAM ***(see back of form for appropriate code)***

☐ **POPULATION AT RISK** Code ______________ ☐ **GENERAL SCREENING** Code ______________

PHYSICIAN'S NAME AND ADDRESS

CURRENT TB CONTACT

☐ **TYPE 1** - Household or share the same air space for greater than 4 hours per/week

☐ **TYPE 2** - Non-household or share the same air space for 2 - 4 hours per/week

☐ **TYPE 3** - Casual or share the same air space for less than 2 hours per/week

NAME OF PERSON WITH TB OR TB#

LAST DATE OF CONTACT (yyyy/mm/dd)

RISK FACTORS FOR DEVELOPING TB

- ☐ Cancer (specify) ______________
- ☐ BMI < 20
- ☐ Alcoholism
- ☐ Drug Use (specify) ______________
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Travel to high prevalence country (specify) ______________
- ☐ Smoker
- ☐ None of the above
- ☐ Renal Disease, Failure, Dialysis (specify) ______________
- ☐ Silicosis, Sarcoidosis, Asbestosis (specify) ______________
- ☐ Immunosuppressive Medication eg. Prednisone, anti-rejection, chemotherapy, TNF, methotrexate ______________ ______________

Specify dosage and duration ______________ ______________

SYMPTOMS ☐ Cough ☐ Blood in sputum ☐ Fever ☐ Weight loss ☐ None
☐ Sputum ☐ Night sweats ☐ Fatigue ☐ Chest pain (non angina) **Sputum collected for AFB?** Yes ☐ No ☐

HEPATITIS HISTORY? ☐HEP B ☐HEP C ☐UNKNOWN ☐NO

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

HAS CLIENT EVER BEEN IN CONTACT WITH TB CASE PRIOR TO CURRENT EXPOSURE?
☐YES IF YES, YEAR ______________ MONTH______________ ☐NO

RESULT OF LAST TST? ☐NO PRIOR TST ☐NO INDURATION ☐POSITIVE ________mm WHEN? (YYYY/MM/DD) WHERE?

RESULT OF LAST IGRA? ☐NO PRIOR IGRA ☐NEGATIVE ☐POSITIVE WHEN? (YYYY/MM/DD) WHERE?

DID NOT TEST ☐Previous TB ☐Previous Positive TST ☐Refused TST ☐Previous Positive IGRA

TUBERCULIN SKIN TEST *(see interpretation on back - Part 2)*

INITIAL TST:	*Community/Agency name* / LOT #:	DATE GIVEN: (yyyy/mm/dd) / SITE:	GIVEN BY:	DATE READ:	SIZE OF REACTION mm	READ BY:

RECOMMENDATIONS: ☐ No further testing ☐ 2 - step required ☐ Repeat as required in ______ weeks ☐ Recommend X-Ray

SECOND TST:	*Community/Agency name* / LOT #:	DATE GIVEN: (yyyy/mm/dd) / SITE:	GIVEN BY:	DATE READ:	SIZE OF REACTION mm	READ BY:

RECOMMENDATIONS: ☐ No further testing ☐ Recommend X-Ray

REASON FOR NOT HAVING CHEST X-RAY ☐PREGNANT ☐REFUSED ☐OTHER (specify) ______________________

PART 3

TB PHYSICIAN COMPLETES

RECOMMENDATION AFTER X-RAY

☐ No evidence of active TB ☐ LTBI letter (low risk reactor) ☐ Incomplete (X-Ray/Report not received)
☐ See Doctor's Report/Follow up required ☐ IGRA Candidate ☐ X-Ray technique unsat. - Repeat

PHYSICIAN'S SIGNATURE ______________________ DATE - yyyy/mm/dd

ACCESS TO INFORMATION AND PROTECTION OF PRIVACY ACT

The personal information collected on this form is used for the purpose of enabling YCDC TB Control to carry out a screening program; and is collected under the authority of Yukon's *Health Act.*

Questions about the use and collection of this information can be directed to Yukon Communicable Disease Control @ (867) 667-8323 or toll free @ 1-800-661-0408 ext 8323

YG(5298)NC2 Rev.09/2013 White Copy - TB Control Yellow Copy - Chart Copy

Yukon Communicable Disease Control – TB Control
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APPENDIX K-1 (Page 2)

Instructions for Completing Form

Part 1: Nurse Completes

Reason for Exam: **Population at risk screening**

01 LCCF, Resident (Continuing Care, Respite)
02 LCCF, Adult Care Employee
03 LCCF, Child Care Employee
05 Health Employee (Hospital)
06 Public Service Employee (Police, Fire)
08 Correctional Centre Resident
11 Volunteer
13 Detox

General Screening

20 Ophthalmology Referral
22 Doctor's Referral
23 Immigration
24 Self-Referral, Symptoms
25 Self-Referral, Healthy
26 Other ____________
27 Student
30 Employment, Other

Part 2

Clients with a tuberculin skin test (TST) of **10mm or greater** should be referred for X-ray

Clients with a tuberculin skin test (TST) of **5mm or greater** who are contacts or immunosuppressed should be referred for X-ray

Clients with a history of TB or a previously positive tuberculin skin test of **10mm or greater** should be referred for X-ray

If client is a TB contact and the first tuberculin skin test is **4mm or less**, repeat the TST in 8-12 weeks post contact, and forward copy of form to YCDC – TB Control

APPENDIX K-2

REQUEST FOR XRAY

PATIENT NAME ____________ (last name) ____________ (first name)

D.O.B. ____________ (day / month / year)

HEALTH CARE # ____________

ORDERING PHYSICIAN : ____________ (print name) ____________ (signature) M.D.

CC : ____________

Note : CC applies to Yukon Physician's only. Reports going to non Yukon Physicians are the clinics responsibility. Film release forms are required for Film CD requests.

☐ **A** - Within 48 hours
☐ **B** - Within 1 - 2 weeks
☐ **C** - Within 3 months

SPECIAL APPOINTMENT REQUESTS / CONTACT INFORMATION ____________

STUDY REQUESTED ✱All ortho views must be ordered by an orthopaedic surgeon

Upper Extremity

	right	left	bilateral
☐ Finger	☐	☐	☐
☐ Hand	☐	☐	☐
☐ Wrist	☐	☐	☐
☐ Scaphoid	☐	☐	☐
☐ Forearm	☐	☐	☐
☐ Elbow	☐	☐	☐
☐ Humerus	☐	☐	☐
☐ AC Joints	☐	☐	☐
☐ Clavicle	☐	☐	☐
☐ SC Joints	☐	☐	☐
☐ Scapula	☐	☐	☐
☐ Shoulder	☐	☐	☐

Lower Extremity

	right	eft	bilateral
☐ Toe	☐	☐	☐
☐ Foot	☐	☐	☐
☐ Calcaneus	☐	☐	☐
☐ Ankle	☐	☐	☐
☐ Tib-Fib	☐	☐	☐
☐ Knee	☐	☐	☐
☐ Patella	☐	☐	☐
☐ Femur	☐	☐	☐
☐ Hip	☐	☐	☐

Pelvis
☐ Pelvis

Skull / Facial Bones
☐ Skull
☐ Sinuses
☐ Facial Bones
☐ Nasal Bones
☐ Orbits
☐ Mandible
☐ TM Joints

Thorax
☐ Chest
☐ Ribs
☐ Sternum
☐ Soft Tissue Neck

Abdomen
☐ Abdomen Series (3 views)
☐ Supine
☐ Erect

Spine
☐ Cervical Spine ☐ with obliques
☐ Thoracic Spine
☐ Lumbar Spine ☐ with obliques
☐ Sacrum
☐ Coccyx
☐ SI Joints
☐ Scoliosis Series

Other
☐ (specify) ____________

TO LOOK FOR / RELEVANT HISTORY / RELEVANT SURGICAL HISTORY

TECH NOTES :

Previous relevant imaging studies?
☐ NO ☐ YES Location ____________
type of study ____________

✱✱ Previous imaging reports MUST be FAXED with request form if not available at WGH

0014174 5 Hospital Road, Whitehorse, Yukon Y1A 3H7 PHONE: (867) 393-8738 FAX: (867) 393-8775 www.whitehorsehospital.ca

APPENDIX K-3

Health and Social Services

Yukon Communicable Disease Control
Tuberculosis Program
#4 Hospital Road
Whitehorse, YT Y1A 3H8
Telephone: 867-667-8323
Fax: 867-667-8349

Date

Dear DOB:

I am contacting you in follow up to your recent screening for tuberculosis (TB). A physician at British Columbia TB Control has reviewed your chest x-ray and screening form.

Your chest x-ray does not show any signs of active tuberculosis. However, your positive TB skin test may show that you have been infected with the tuberculosis bacteria in the past. This is referred to as latent TB infection (LTBI). The bacteria is dormant and you cannot pass it on to your family or friends.

There is a small risk of developing an active form of tuberculosis at some point in your life. The risk can be significantly reduced by taking daily medications for several months. This medication is well tolerated by most people and is provided free of charge.

If you are interested in discussing treatment of LTBI please contact Yukon Communicable Disease Control:

TB Nurses: Melanie or Beth
867-667-8323 or 1-800-661-0408 extension 8323

If you choose not to complete treatment for LTBI and future screening is required for school or work, a symptom inquiry and chest x-ray is needed.

If you are diagnosed with known risk factors for developing active TB, please contact YCDC TB nurses as further testing may be appropriate. These risk factors include:

- contact with active TB
- immune suppressing disease, for example, HIV
- cancer
- diabetes
- kidney failure
- taking immune suppressing medications such as high dose prednisone

For more information or to discuss these recommendations please contact us at 867 667-8323.

Sincerely,

Elizabeth Roberts RN BScN Melanie Stangeland RN
Cc:

Yukon Communicable Disease Control – TB Control
4 Hospital Road, Whitehorse, YT Y1A 3H8
Phone: 667-8323 Fax: 667-8349

APPENDIX K-4

Patient name: ______________________
DOB: ______________________
TB#/PHN#: ______________________

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

Request for Preventative Therapy

☐ Client has been informed of the indications for preventative therapy and potential side effects of prescribed medications.

☐ Client accepts responsibility for taking medications as prescribed, and reporting side effects to the responsible health care provider.

☐ Client completes appropriate blood work as recommended by TB Control (TBC) and health care provider.

☐ Client authorizes TBC to request any or all information related to the medical condition including medication history from Pharmanet.

☐ Client has refused preventative therapy:

Client Signature: ______________________ Date: ______________

Nurse's Signature: ______________________ Date: ______________

Coordinating Health Unit:

- Responsible for dispensing medication, monitoring side effects and ensuring required blood work is completed.
- Responsible for reporting any abnormal AST/ALT (See TB Control manual) results and side effects to TBC.

Please include:

1). Result of most recent x-ray (within last 6 months): _______ Date ____________

2). Result of most recent AST (within last 6 months): _______ Date ____________

3). Medication allergies: ______________________

Reaction ______________ Severity ____________

4). Weight: ____________

Comments: ______________________

PLEASE FAX COMPLETED FORM TO YCDC TB CONTROL
(867) 667-8349

APPENDIX K-5

DIRECTLY OBSERVED THERAPY (DOT) CHECKLIST

NAME:		D.O.B:		GENDER: [ ]
ADDRESS:		CITY:		YT
YHIS# :		PHONE:		
MEDICATION PRESCRIPTION:		START DATE:		
		ALLERGIES:		

SIGNS \ SYMPTOMS CHECKLIST ✓ = YES X = NO

DATE:	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat
RASH \ ITCHING														
FEVER \ CHILLS OR ACHES (FLU LIKE)														
TINGLING OF HANDS OR FEET														
YELLOWING OF EYES OR SKIN														
VERY TIRED \ WEAK														
DIZZY \ UNSTEADY														
TROUBLE SEEING														
NAUSEA \ VOMITING														
JOINT PAIN														
ABDOMINAL PAIN														
NOTES:														
NURSE NOTIFIED														
DIRECTLY OBSERVED THERAPY														
PILLS TAKEN														
DISPENSER'S INITIALS														
FOLLOW UP TEST REMINDERS KEY: [L] - Letter Sent [V] - Verbal [C] - Complete														
CHEST X-RAYS														
SPUTUM (AFB)														
BLOOD WORK														
WEIGHT														
HEALTH CARE PROVIDER INITIALS														

INITIALS	SIGNATURE	TITLE:

Yukon Communicable Disease Control – TB Control
4 Hospital Road, Whitehorse, YT Y1A 3H8
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APPENDIX K-6

STOP

AIRBORNE PRECAUTIONS IN EFFECT

DOOR MUST BE KEPT CLOSED

AND

ANYONE ENTERING THIS ROOM MUST WEAR AN N95 RESPIRATOR

UNTIL: