fraserhealth Better health. Best in health care.

Name of Person in Care: _____

TUBERCULOSIS RISK ASSESSMENT FORM FOR PERSONS IN CARE OF COMMUNITY CARE FACILITIES – 60 YEARS AND OLDER

Residents **60 years and older** will be assessed for symptoms of active TB and risks for developing active disease, and if symptomatic or at risk, referred for further evaluation including a chest x-ray prior to admission.

Symptoms of TB include: productive, prolonged cough (lasting more than three weeks); hemoptysis (coughing up blood); fever, weight loss, night sweats (with no other confirmed diagnosis); non-resolving pneumonia.

Risk factors for developing active TB disease include: substantial immune suppression (especially people with HIV/AIDS), and known contacts to individuals with infectious TB disease within the prior two years.

Please check one of the following boxes:

- ❑ **Yes**, presence of symptoms or risk factors is applicable and documentation of further tuberculosis testing will be provided.
- ❑ **No**, presence of symptoms or risk factors listed above is applicable.
- ❑ **Unknown,** cannot determine presence of above listed risk factors as history is not known.

Name of person filling out form:

*(print name)*_____

(*signature)*_____

*(relationship to person in care)*_____

To be completed by the facility:

* **Presence of symptoms or risk factors or an unknown history requires documentation of further follow-up.**

- ❑ Documentation Received

Date of receipt:_____

fraserhealth Better health. Best in health care.

Note: This form is only applicable to persons in care age 13 years and older. As vaccination recommendations change frequently please check the BC Communicable Disease Control website for current recommendations:
www.bccdc.ca/health-info/immunization-vaccines/immunization-schedules

Name of Person in Care: _____

PERSON IN CARE IMMUNIZATION RECORD

PART A - *To be completed upon admission to the facility.*

To the best of my knowledge my current immunization status is as indicated below.
Recommended Immunizations: *(check one box for each immunization listed)*

Immunization	Yes	No	Unknown	Frequency of Booster
▪ Tetanus and Diphtheria (Td)	❑	❑	❑	*Date of last booster (if known)* _____
▪ Measles ***Required if born after 1956***	❑	❑	❑	None
▪ Rubella (MMR)	❑	❑	❑	None
▪ Mumps (MMR) ***Required if born after 1956***	❑	❑	❑	None
▪ Influenza	❑	❑	❑	Annually *Date of last immunization (if known)* _____
▪ Pneumococcal	❑	❑	❑	None
▪ Hepatitis B ***Developmentally challenged or certain chronic illnesses only***	❑	❑	❑	No booster required.

Medical certificate/record of vaccinations is provided *(if available)* ❑ Yes ❑ No

Person in care or alternate's signature: _____

Relationship to person in care: _____

Date: _____

PART B – *To be completed by the Facility*

Resident immunization status for the above recommended immunizations is:

❑ **Complete** *(person in care has all recommended immunizations)*
Medical certificate/record is on file ❑ Yes ❑ No ❑ Not available

❑ **Incomplete**
If incomplete or unknown immunization status: *(check all that apply)*
- ❑ Person in Care encouraged to obtain recommended immunizations.
- ❑ Person in Care has obtained recommended immunizations or boosters and provided verification.

❑ Facility's policy regarding accommodating persons in care who are not immunized or incompletely immunized was reviewed with this person in care or alternate.

Reviewed by: _____ Date: _____