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: ________________________________

Revised: March 14, 2016
CCFL – RES 301b

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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)

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th>Frequency of Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus and Diphtheria (Td)</td>
<td></td>
<td></td>
<td></td>
<td>Date of last booster (if known)</td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Mumps (MMR)</td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td></td>
<td></td>
<td>Annually Date of last immunization (if known)</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td></td>
<td></td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td>No booster required.</td>
</tr>
</tbody>
</table>

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: __________________________