Name of Person in Care: ____________________________

TUBERCULOSIS RISK ASSESSMENT FORM
FOR PERSON IN CARE OF COMMUNITY CARE FACILITIES – LESS THAN 60 YEARS OLD

Residents less than 60 years old: if any of the following risk factors exist for you (person in care named above) you must be referred to the local Health Unit or your doctor for further testing. Please read the list of risk factors carefully and indicate if you need to be referred for further testing. (Please note that you do not need to indicate which risk factor exists).

- those who in the past five years have lived or worked in a country with a high prevalence of tuberculosis. (Including China, Vietnam, Philippines, Hong Kong, Indian Subcontinent, Eastern Europe, Africa, Mexico, Korea)
- those of aboriginal ancestry
- those who are symptomatic (i.e. chronic cough, weight loss, night sweats)
- those with a previous history of tuberculosis
- those who are immunocompromised
- those with a history of non-resolving pneumonia
- those with a history of drug or alcohol addiction
- those with a known contact to infectious TB disease within the prior two years

Please check one of the following boxes:

- Yes, one or more of the above risk factors is applicable and documentation of further tuberculosis testing will be provided.
- No, none of the 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 any of the above risk factors or an unknown history requires referral to a physician for further follow-up.

- Referred to physician Date of referral: _______________________
  Name of physician: ______________________________________
  Referred by: (print name) _________________________________
  (signature) ____________________________________________

Revised: March 14, 2016
CCFL – RES 301c
Community Care Facilities Licensing, Health Protection
**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 Required if born after 1956</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) Required if born after 1956</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 Developmentally challenged or certain chronic illnesses only</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: ____________________________