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

TUBERCULOSIS PROGRAM

☐ BILL TO TB CONTROL ☐ PAYMENT RECEIVED MSP BILLING # 99996

TODAY'S DATE (YYYY/MM/DD) | PERSONAL HEALTH (PHN) NUMBER

TB CONTROL USE ONLY

☐ VAN ☐ NW ☐ FO ☐ TBSAC | TB NUMBER | ☐ ID CHECKED | ☐ MAIL ☐ PICKUP

PART 1: CLIENT COMPLETES (use ink and press firmly)

LAST NAME | GIVEN NAME(S) | MAIDEN NAME (IF APPLICABLE)

FULL ADDRESS | CITY | PROVINCE | POSTAL CODE

DATE OF BIRTH (YYYY/MM/DD) | GENDER ☐ M ☐ F | ETHNIC ORIGIN | FIRST NATIONS ☐ REGISTERED ☐ NON-REGISTERED ☐ ON RESERVE ☐ OFF RESERVE | ABORIGINAL COMMUNITY

COUNTRY OR CANADIAN PROVINCE OF BIRTH | DATE ENTERED CANADA (YYYY/MM/DD) | HOME PHONE NUMBER | WORK PHONE NUMBER

NAME OF FAMILY PHYSICIAN | PHONE NUMBER OF FAMILY PHYSICIAN

PART 2: NURSE COMPLETES

REASON FOR EXAM (CODES ON BACK)
☐ POPULATION AT RISK, CODE: ☐ GENERAL, CODE:

CONTACT INFORMATION
☐ TYPE 1 ☐ TYPE 2 ☐ TYPE 3

TYPE 1: HOUSEHOLD OR > 4HR/WEEK
TYPE 2: NON-HOUSEHOLD OR 2-4 HR/WEEK
TYPE 3: CASUAL OR <2 HR/WEEK

CURRENT TB EXPOSURE? IF YES, NAME OF TB CASE OR TB#
☐ YES ☐ NO

LAST DATE OF CONTACT (YYYY/MM/DD)

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

RISK FACTORS
☐ HIV ☐ TRANSPLANT (SPECIFY) _____ ☐ END STAGE RENAL DISEASE/DIALYSIS ☐ CANCER (SPECIFY) _____
☐ PREDNISONE/IMMUNE SUPPR. MEDS (SPECIFY) _____ ☐ DIABETES ☐ TRAVEL TO HIGH PREVALENCE COUNTRY (SPECIFY) _____
☐ NONE ☐ OTHER (SPECIFY)

SYMPTOMS
☐ COUGH ☐ SPUTUM ☐ BLOOD IN SPUTUM ☐ NIGHT SWEATS ☐ FEVER ☐ WEIGHT LOSS ☐ CHEST PAIN ☐ NONE

SPUTUM COLLECTED? ☐ 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

RESULT OF LAST TST ☐ NO INDURATION ☐ POSITIVE: _____ MM

WHEN? (YYYY/MM/DD)

WHERE?

DID NOT TEST
☐ PREVIOUS TB ☐ PREVIOUS POSITIVE TST
☐ REFUSED TST ☐ PREVIOUS POSITIVE IGRA

IGRA TEST? ☐ QTF ☐ T-SPOT

RESULT OF LAST IGRA? ☐ NEGATIVE ☐ POSITIVE

WHEN? (YYYY/MM/DD)

WHERE?

INITIAL TST

GIVEN BY *(ENTER CODE OF HA/HSDA/BRANCH, HOSPITAL, HEALTH CENTRE AND PROVIDER INTIALS)* | DATE GIVEN (YYYY/MM/DD) | DATE READ (YYYY/MM/DD) | SIZE OF REACTION MM | READ BY

RECOMMENDATIONS
☐ NO FURTHER TESTING ☐ REPEAT AS REQUIRED IN _____ MONTHS ☐ RECOMMEND X-RAY

REPEAT TST

GIVEN BY *(ENTER CODE OF HA/HSDA/BRANCH, HOSPITAL, HEALTH CENTRE AND PROVIDER INTIALS)* | DATE GIVEN (YYYY/MM/DD) | DATE READ (YYYY/MM/DD) | SIZE OF REACTION MM | READ BY

RECOMMENDATIONS
☐ NO FURTHER TESTING ☐ RECOMMEND X-RAY

REASON FOR NOT HAVING CHEST X-RAY
☐ PREGNANT ☐ REFUSED ☐ OTHER (SPECIFY):

COMMENTS

PART 3: RADIOLOGY COMPLETES

CHEST X-RAY RESULT
☐ NORMAL ☐ ABNORMAL ☐ OUTSIDE REPORT ONLY

COMMENTS

RADIOLOGIST'S SIGNATURE | DATE SIGNED (YYYY/MM/DD)

PART 4: TB CONTROL PHYSICIAN COMPLETES

X-RAY NUMBER | TODAY'S DATE (YYYY/MM/DD)

RECOMMENDATION AFTER X-RAY
☐ NO EVIDENCE OF ACTIVE TB ☐ TB CONTACT: REPEAT CXR IN _____ MONTHS
☐ SEE PHYSICIAN'S REPORT ☐ CLINIC APPOINTMENT
☐ LTBI – LETTER

TB PHYSICIAN'S SIGNATURE | DATE SIGNED (YYYY/MM/DD)

The information collected on this form is used for the purpose of enabling TB Control to carry out a testing program and is collected under the authority of British Columbia's *Health Act*. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act.

HLTH 939 REV. 2011/02/28 WHITE COPY – TB CONTROL YELLOW COPY – HA/HSDA/BRANCH PINK COPY – PATIENT **INSTRUCTIONS ON BACK**

PRINT RESET

INSTRUCTIONS FOR COMPLETING FORM

PART 2: NURSE COMPLETES

Reason For Exam: **Population at Risk**

01 LCCF, Resident
02 LCCF, Adult Care Employee
03 LCCF, Child Care Employee
04 Extended Care Hospital Resident
05 Health Centre Employee (Hospital)
06 Public Service Employee
07 School Board Employee
08 Correctional Centre Resident
09 Private Home Care Centre Support Ser.
10 Preschool, Parent/Volunteer
11 Volunteer (not Preschool)
13 Detox/Treatment

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
38 Aboriginal School Survey
39 Aboriginal Canadian Survey

CONTACT DEFINITIONS

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

Clients with a TST **10mm or >** should be referred for chest x-ray

Clients with a TST **5mm or >** who are **contacts** or **immunosuppressed** should be referred for chest x-ray

Clients with a history of TB or a previously positive tuberculin should be referred for chest x-ray if TB form required for screening or symptoms or contact investigation

If client is a TB contact and first TST is negative, indicate recommendation and send yellow copy to TB Control.

Do not separate but fold, staple, and instruct client to take form with them when they go for the chest x-ray.

For assistance consult the Division of TB Control (604) 707-2692 or your local Health Unit.

EXTERNAL RADIOLOGY DEPARTMENT – X-RAY RESULTS

NORMAL: Send/fax reports to TB Control

ABNORMAL: Digital chest x-ray – send/fax report to TB Control. TB Control will contact Radiology Facility to inform that image can be posted to the grid.

Not digital chest x-ray – send x-ray with report and 939 form to TB Control for your region.

CC all reports to GP (see Family Physician in Part 1).

655 West 12th Avenue
Vancouver BC
V5Z 4R4
Fax: 604.707.2690

100 – 237 E. Columbia Street
New Westminster BC
V3E 3W4
Fax: 604.707.2694

1952 Bay Street
Victoria BC
V8R 1J8
Fax: 250.519.1505

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

TUBERCULOSIS PROGRAM

☐ BILL TO TB CONTROL ☐ PAYMENT RECEIVED MSP BILLING # 99996

TB CONTROL USE ONLY

☐ VAN ☐ NW ☐ FO ☐ TBSAC	TB NUMBER	☐ ID CHECKED	☐ MAIL ☐ PICKUP

TODAY'S DATE (YYYY/MM/DD)

PERSONAL HEALTH (PHN) NUMBER

PART 1: CLIENT COMPLETES (use ink and press firmly)

LAST NAME	GIVEN NAME(S)	MAIDEN NAME (IF APPLICABLE)

FULL ADDRESS	CITY	PROVINCE	POSTAL CODE

DATE OF BIRTH (YYYY/MM/DD)	GENDER	ETHNIC ORIGIN	FIRST NATIONS	ABORIGINAL COMMUNITY
	☐ M ☐ F		☐ REGISTERED ☐ NON-REGISTERED ☐ ON RESERVE ☐ OFF RESERVE	

COUNTRY OR CANADIAN PROVINCE OF BIRTH	DATE ENTERED CANADA (YYYY/MM/DD)	HOME PHONE NUMBER	WORK PHONE NUMBER

NAME OF FAMILY PHYSICIAN	PHONE NUMBER OF FAMILY PHYSICIAN

PART 2: NURSE COMPLETES

REASON FOR EXAM (CODES ON BACK)
☐ POPULATION AT RISK, CODE: ☐ GENERAL, CODE:

CONTACT INFORMATION
☐ TYPE 1 ☐ TYPE 2 ☐ TYPE 3

TYPE 1: HOUSEHOLD OR > 4HR/WEEK
TYPE 2: NON-HOUSEHOLD OR 2-4 HR/WEEK
TYPE 3: CASUAL OR <2 HR/WEEK

CURRENT TB EXPOSURE? IF YES, NAME OF TB CASE OR TB#	LAST DATE OF CONTACT (YYYY/MM/DD)	HISTORIC EXPOSURE? IF YES, LIST DETAILS (NAME, DATE)
☐ YES ☐ NO		☐ YES ☐ NO

SYMPTOMS
☐ COUGH ☐ SPUTUM ☐ BLOOD IN SPUTUM ☐ NIGHT SWEATS ☐ FEVER ☐ WEIGHT LOSS ☐ CHEST PAIN ☐ NONE

SPUTUM COLLECTED? ☐ YES ☐ NO

PREVIOUS BCG?	IF YES, DATE (YYYY/MM/DD)	BCG SCAR?
☐ YES ☐ NO ☐ UNKNOWN		☐ YES ☐ NO ☐ UNCERTAIN

HAS CLIENT EVER HAD TB?	PREVENTATIVE TREATMENT?	RESULT OF LAST TST	WHEN? (YYYY/MM/DD)	WHERE?
☐ YES ☐ NO	☐ YES ☐ NO	☐ NO INDURATION ☐ POSITIVE: _____ MM		

DID NOT TEST	IGRA TEST?	RESULT OF LAST IGRA?	WHEN? (YYYY/MM/DD)	WHERE?
☐ PREVIOUS TB ☐ PREVIOUS POSITIVE TST ☐ REFUSED TST ☐ PREVIOUS POSITIVE IGRA	☐ QTF ☐ T-SPOT	☐ NEGATIVE ☐ POSITIVE		

INITIAL TST

GIVEN BY *(ENTER CODE OF HA/HSDA/BRANCH, HOSPITAL, HEALTH CENTRE AND PROVIDER INTIALS)*	DATE GIVEN (YYYY/MM/DD)	DATE READ (YYYY/MM/DD)	SIZE OF REACTION MM	READ BY

RECOMMENDATIONS
☐ NO FURTHER TESTING ☐ REPEAT AS REQUIRED IN _____ MONTHS ☐ RECOMMEND X-RAY

REPEAT TST

GIVEN BY *(ENTER CODE OF HA/HSDA/BRANCH, HOSPITAL, HEALTH CENTRE AND PROVIDER INTIALS)*	DATE GIVEN (YYYY/MM/DD)	DATE READ (YYYY/MM/DD)	SIZE OF REACTION MM	READ BY

RECOMMENDATIONS	REASON FOR NOT HAVING CHEST X-RAY
☐ NO FURTHER TESTING ☐ RECOMMEND X-RAY	☐ PREGNANT ☐ REFUSED ☐ OTHER (SPECIFY):

COMMENTS

PART 4: TB CONTROL PHYSICIAN COMPLETES

X-RAY NUMBER	TODAY'S DATE (YYYY/MM/DD)

RECOMMENDATION AFTER X-RAY
☐ NO EVIDENCE OF ACTIVE TB ☐ TB CONTACT: REPEAT CXR IN _____ MONTHS
☐ SEE PHYSICIAN'S REPORT ☐ CLINIC APPOINTMENT
☐ LTBI – LETTER

TB PHYSICIAN'S SIGNATURE	DATE SIGNED (YYYY/MM/DD)

The information collected on this form is used for the purpose of enabling TB Control to carry out a testing program and is collected under the authority of British Columbia's *Health Act*. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act.