island health

Client Name: **MRN:** **Date of Birth:** *Affix client label*

Health History for Clients Entering Long-Term Care and/or Facility Respite

Instructions:

- Complete and sign Health History information below ***and*** Tuberculosis (TB) Screening (either Part A ***or*** Part B).
  - TB screening results (CXR/TST) to be included, if current within 6 months.
  - If TB screening still required:
    1. Fax **Request for Tuberculosis Screening Information from Primary Care Provider** letter, or refer to TB Services (if no PCP)
    2. Once results received, upload via Portal per the usual process
- This completed form is to be included as part of the LTC and/or Facility Respite application.
- For reference, please see the Long Term Care Access Administrative Procedure (LACM 16) and/or the Facility Respite Care Program Referral Process document for a complete list of documents to be submitted along with your client's application form.

Health History Information	
Documents Included	*Upload the following documents (current within the last six months):*
□	Diagnostics (labwork, medical, CXR result, TST result)
□	Consults (e.g., EHR documents, medical Hx, psychosocial Hx, diagnoses, and surgeries)
□	Immunization Status (Consult CareConnect as needed): Tetanus: □ Yes (year:_____) □ No □ Unknown Pneumovax: □ Yes (year:_____) □ No □ Unknown Covid-19 Immunization: □ Yes (date of last dose:_____) □ No □ Unknown Influenza: □ Yes (date of last dose:_____) □ No □ Unknown

Cognition and Substance Use (for Facility Respite use only)			
1. Cognitive test scores *(only if already completed & available)*: □ Not applicable **MMSE** Test date: _____ Score: __/30 **MoCA** Test date: _____ Score: __/30			
2. Smoker	□ Yes	□ No	□ Unknown
3. Substance use	□ Yes	□ No	□ Unknown

SIGNED: _____

Date: YYYY/MM/DD	**Name:**	**Designation:**	**Telephone:**

island health

Client Name:
MRN:
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Affix client label

TUBERCULOSIS SYMPTOM & RISK FACTOR SCREENING TOOL

Symptoms of active TB may include:
Cough (esp. productive), Hemoptysis, Night Sweats, Fever, Recent Weight Loss, Chest Pain, and Lymphadenopathy

CURRENT ATTENDING PHYSICIAN MUST COMPLETE AND SIGN PART A OR PART B
PLEASE ONLY MARK THE APPROPRIATE BOXES

PART A
For clients who are currently LESS THAN 60 years of age

1. Unless contraindicated, **a TUBERCULIN SKIN TEST (TST) within the past six months is REQUIRED** *(Please check all appropriate boxes on the right)*	□ TST Contraindicated ***(proceed to Section 2 below)*** □ TST Completed RESULT: □ Negative. If **NEGATIVE** no further testing is required ***unless*** client is symptomatic (see Section 2) □ Positive. If **POSITIVE** a CHEST X-RAY is **REQUIRED** □ Chest X-Ray Completed RESULT: □ Negative. If **NEGATIVE** no further testing is required □ Positive. If **POSITIVE** referral to TB Services is required □ Referral to TB Services completed ***(completion of Section 2 is not required)***
2. IF TST is contraindicated **OR IF *the client is symptomatic**** a CHEST X-RAY is REQUIRED □ TST Contraindicated □ Client is symptomatic *(Please check all appropriate)*	□ Chest X-Ray Completed RESULT: □ Negative. If **NEGATIVE** no further testing is required □ Positive. If **POSITIVE** referral to TB Services is required □ Referral to TB Services completed

SIGNED: _____

Date: YYYY/MM/DD	**Name:**	**Designation:**	**Telephone:**

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Client Name: **MRN:** **Date of Birth:** *Affix client label*

Symptoms of active TB may include:
Cough (esp. productive), Hemoptysis, Night Sweats, Fever, Recent Weight Loss, Chest Pain, and Lymphadenopathy

CURRENT ATTENDING PHYSICIAN MUST COMPLETE AND SIGN PART A OR PART B
PLEASE ONLY MARK THE APPROPRIATE BOXES

PART B
For clients who are 60 years of age or older

1. Is this client symptomatic?* □ Yes. **(CHEST X-RAY is required**; please indicate results in the column to the right) □ No. ***(proceed to 2 below)***	□ Chest X-Ray Completed RESULT: □ Negative. If **NEGATIVE** no further testing is required □ Positive. If **POSITIVE** referral to TB Services is required □ Referral to TB Services completed ***(completion of Section 2 is not required)***
2. Does the client have any of the following risk factors (mark all that apply): □ HIV/AIDS □ Organ Transplant □ Substance Use □ Is an immigrant from a High Prevalence Country** □ Recent travel to a High Prevalence Country** □ Homeless or under-housed □ Immune suppressing medication □ History of hepatitis □ History of tuberculosis ***(now complete the right-hand column)***	□ None of these risk factors are present and therefore ***CHEST X-RAY IS NOT REQUIRED*** □ One (or more) risk factors apply as indicated on the left and therefore a **CHEST X-RAY IS REQUIRED** □ Chest X-Ray Completed RESULT: □ Negative. If **NEGATIVE** no further testing is required □ Positive. If **POSITIVE** referral to TB Services is required □ Referral to TB Services completed

SIGNED: _____

Date: YYYY/MM/DD	**Name:**	**Designation:**	**Telephone:**

****High Prevalence Countries:** Brazil, Russian Federation, *AFRICA* (including Angola, Central African Republic, Congo, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Liberia, Mozambique, Namibia, Nigeria, Sierra Leone, South Africa, Tanzania, Zambia, Zimbabwe); *SOUTH ASIA* (including Bangladesh, India, Pakistan); *SOUTH EAST ASIA* (including Cambodia, China, Indonesia, Myanmar, North Korea, Papua New Guinea, Philippines, Thailand, Vietnam)