Grey Bruce Public Health

# TB Screening Tool for Long-Term Care and Retirement Homes

| | |
|---|---|
| **Name of Resident:** | |
| **DOB:** | |
| **Health Care Provider:** | |

## Screening Assessment

**Date Completed (yyyy/mm/dd):**

**Completed by (name/signature/designation):**

Residents who have signs/symptoms of TB disease or significant risk factors for TB disease require a posteroanterior and lateral chest x-ray to rule out TB disease. Residents should be referred to a health care provider for further follow up. *Please note that elderly persons may present with atypical signs and symptoms of tuberculosis. Health care providers should consider tuberculosis as a differential diagnosis in residents with failure to thrive who have risk factors for TB.*

| | Symptom | Onset Date (YYYY/MM/DD) | Symptom | Onset Date (YYYY/MM/DD) |
|---|---|---|---|---|
| **Signs and Symptoms** | ☐ Asymptomatic | | ☐ Weight loss | |
| | ☐ New/worsening cough greater than 3 weeks duration | | ☐ Fatigue | |
| | ☐ Non-resolving pneumonia | | ☐ Night sweats | |
| | ☐ Hemoptysis | | ☐ Loss of appetite | |
| | ☐ Chest Pain | | ☐ Shortness of Breath | |
| | ☐ Fever | | ☐ Other | |

**MEDICAL RISK FACTORS** ☐ **Yes** ☐ **No**

- ☐ HIV/AIDS
- ☐ End Stage Renal Disease / Chronic Renal Failure requiring hemodialysis
- ☐ Organ Transplant Recipient
- ☐ Silicosis or fibronodular disease
- ☐ Head and neck carcinoma
- ☐ Diabetes
- ☐ Persons taking tumor necrosis factor alpha inhibitors or glucocorticoid treatment (>15mg/day prednisone)
- ☐ Persons who use injection drugs

**OTHER RISK FACTORS** ☐ **Yes** ☐ **No**

- ☐ Contact of TB disease case
- ☐ Foreign born or Indigenous born Canadian
- ☐ Born in a high incidence country (specify):
- ☐ Travelled in a high incidence country (specify):
- ☐ Previous TB disease (active TB)
- ☐ Previous TB infection (latent TB)

**If resident has had previous TB disease or TB infection, include treatment information below if applicable:**

Treatment Regime (medication, dose, frequency):

**Completed Treatment:** ☐ **Yes** ☐ **No**

*(Specify year completed yyyy/mm/dd):*

Grey Bruce Public Health

# TB Screening Tool for Employees

| | | | |
|---|---|---|---|
| **Name of Staff:** | | **Phone #:** | |
| **DOB:** | | **Address:** | |
| **Health Care Provider:** | | | |

## Screening Assessment

**Date Completed (yyyy/mm/dd):**

**Completed by (name/signature/designation):**

Any employee exhibiting signs or symptoms of tuberculosis (TB) should be referred to a healthcare provider for further evaluation.

Employees with a positive tuberculin skin test (TST) should undergo a medical assessment to rule out active TB disease. If the positive TST is their first ever, the evaluation should include a chest X-ray.

Asymptomatic employees who have been advised not to undergo future TSTs should be screened annually for TB symptoms, risk factors, and potential exposures. Repeated chest X-rays are not required in these cases.

**TUBERCULOSIS SKIN TEST (TST):**

Previous Positive TST: ☐ No ☐ Yes If yes specify:

Previous Chest Xray for TB screening: ☐ No ☐ Yes If yes specify:

Negative TST completed in the last 12 months? ☐ No ☐ Yes If yes specify:

TST screening required upon hire? ☐ No ☐ Yes

| TST | Date Planted | Date Read | Read by: | Results (mm) |
|---|---|---|---|---|
| **Step 1 TST:** | | | | |
| **Step 2 TST:** | | | | |

Note: If employee has a previous documented 2 step TST, only a 1 step is required.

**SIGNS AND SYMPTOMS**

| Symptom | Onset Date (YYYY/MM/DD) | Symptom | Onset Date (YYYY/MM/DD) |
|---|---|---|---|
| ☐ Asymptomatic | | ☐ Weight loss (unintended) | |
| ☐ Cough greater than 2 weeks duration | | ☐ Fatigue | |
| ☐ Non-resolving pneumonia | | ☐ Night sweats | |
| ☐ Hemoptysis | | ☐ Loss of appetite | |
| ☐ Chest Pain | | ☐ Shortness of Breath | |
| ☐ Fever | | ☐ Other (specify): | |

**MEDICAL RISK FACTORS** ☐ **Yes** ☐ **No**

☐ Current or planned immune suppression

☐ Other (specify):

**OTHER RISK FACTORS** ☐ **Yes** ☐ **No**

☐ Contact of TB disease case

☐ Born in a high incident country (specify):

☐ Travelled in a high incident country (specify):

☐ Previous TB disease (active TB)

☐ Previous TB infection (latent TB)

**If employee has had previous TB disease or TB infection include treatment information below if applicable:**

Treatment Regime (medication, dose, frequency):

**Completed Treatment:** ☐ **Yes** ☐ **No**

*(Specify year completed):*