



SCREEN FOR TB RISK IN HOME CARE CLIENTS

Client Name: _____

Date: _____

Gender: _____

Band:

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D.O.B.: /_____/_____/_____/_____

PHN:

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yyyy mm dd

Are Current Symptoms Present?

- Cough > 3 weeks _____ (onset/duration)
- Unexplained weight loss _____ (amount over what period)
- Fever (night sweats) _____ (describe no temp taken)
- Unexplained loss of appetite _____ (describe)
- Hemoptysis _____ (onset/duration/amount)

If NO symptoms

If symptoms present

- Referral to family doctor/NP for assessment **and**
- Referral to public health TB program by faxing a copy of this form/work with Public Health to collect sputum x3 for AFB

Are Risk Factors for TB Present

- HIV/AIDS
- History of or upcoming solid organ transplant
- Silicosis (lung fibrosis caused by the inhalation of dust containing silica)
- Chronic Renal Failure
- Carcinoma of head/neck
- Diabetes
- Hemotologic Malignancies (leukemia, lymphoma)
- History of tuberculosis _____ (specify)

Treatment with immuno-suppressant drugs? (specify drug and start date/duration)

- Glucocorticoids (>15 mg/day for >1 month) _____
- Cyclosporine A _____
- Tumor necrosis factor alpha inhibitors _____
 - a) Humira
 - b) Remicade
 - c) Cimzia
 - d) Enbrel
 - e) Other (specify) _____
- Azathioprine (Imuran) _____
- Lefluonomide _____
- Cancer chemotherapy _____
- Psoriasis medications _____

If no risk factors or treatment then NO further follow up is necessary at this time.

Clients with latent TB infection but no other risk factors have a lesser but not zero risk of active TB in the future. Be aware of TB symptoms in your clients.

YES. Risk factors or treatments are present

- Referral to Public Health TB program by faxing them a copy of this form.

Signature: _____

Date Screen completed: _____

(yyyy-mm-dd)

Copy to Community Health Tuberculosis Program _____