

Tuberculosis Screening for Staff/Volunteers/Students

The BC TB Screening Guidelines have been recently updated (November, 2015)¹. BC TB Screening Guidelines are explicit for Health Care Providers, and recommendations for screening of volunteers and students are determined locally based on risk.

Due to the low prevalence of TB within Adult Licensed Residential Community Care Facilities within Fraser Health, the following local guidance has been authorized by the Medical Health Officer:

- 1) **All health care providers, volunteers and students are required** to be screened for *symptoms of active TB disease* and *risks for developing active TB disease*, and provide proof of follow-up assessment if symptomatic or at risk *prior to commencing work*.
 - a) *Symptoms of active TB include:*
 - Productive, prolonged cough (lasting more than three weeks)
 - Hemoptysis (coughing up blood)
 - Fever, weight loss, night sweats, unexplained weight loss, fatigue (with no other confirmed diagnosis)
 - Non-resolving pneumonia
 - b) *Risk factors for development of active TB disease include:*
 - Those with substantial immune suppression, especially people with HIV infection/AIDS
 - Known contacts to infectious TB disease within the prior two years, especially those with substantial immune suppression

Symptom and Risk Factor Screening (select one)

- I confirm that I do NOT have symptoms of active TB OR risk factors for developing active TB disease;
OR
- I will provide the facility documentation from my health care provider that I have been assessed for either my symptoms of active TB or my risk for developing active TB disease.

- 2) **All health care providers, volunteers and students are recommended** to undergo a TST upon starting employment. A chest x-ray and referral to TB Services may be necessary if the individual is symptomatic, a TST is contraindicated, the TST is positive (>10 mm) or the individual is immune compromised. **Health care providers, volunteers and students are no longer required to provide proof of TST/chest x-ray screening to the Facility.**
 - a) Staff/volunteers/students seeking TST screening and do NOT have symptoms or risk factors for developing active TB should follow-up with their health care provider or a local travel medicine clinic. Please note, local public health units are no longer providing TST screening for employment purposes.

Acknowledgement of receipt of information of TB screening

- I acknowledge that I am aware of the recommendation to undergo TB screening (TST and/or chest x-ray and referral to TB Services as required).

Name (please print): _____

- Employee
 Volunteer
 Student

Signature: _____

Date: _____

¹ www.bccdc.ca/resource-gallery/Documents/Communicable-Disease-Manual/Chapter%204%20-%20TB/TB_Manual_2015.pdf

As vaccination recommendations change frequently, please check the BC Communicable Disease Centre website for current recommendations: www.bccdc.ca/health-info/immunization-vaccines/immunization-schedules

Employee Name: _____

EMPLOYEE IMMUNIZATION RECORD

PART A - To be completed by the employee upon hire.

Recommended Immunizations: (check one box for each immunization listed)

Immunization	Yes	No	Unknown	Frequency of Booster
▪ Tetanus and Diphtheria (Td)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of last booster (if known) _____
▪ Measles <i>Required if born after 1956</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	None
▪ Rubella (MMR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	None
▪ Mumps (MMR) <i>Required if born after 1956</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	None
▪ Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Annually Date of last immunization (if known) _____
▪ Poliomyelitis (OPV / IPV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	One-time adult booster for health care workers.
▪ Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No booster required.

Medical certificate/record of vaccinations is provided (if available) Yes No

Employee signature: _____

Date: _____

PART B – To be completed by the Employer

Employee immunization status for the above recommended immunizations is:

Complete (employee 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)

- Employee encouraged to obtain recommended immunizations.
- Employee has obtained recommended immunizations or boosters and provided verification.
- Facility's policy regarding accommodating employees who are not immunized or incompletely immunized was reviewed with this employee.

Reviewed by: _____ Date: _____