



Communicable Disease Health Screening

Volunteer
 Spiritual Care Volunteer
 RMFR Volunteer
 Co-Op Student

Last Name: <small>PLEASE PRINT CLEARLY</small>	First Name: <small>PLEASE PRINT CLEARLY</small>
Date of Birth: DD/MM/YYYY	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Telephone Number:	Country of Birth:

Dear Attending Physician:

In accordance with Scarborough Health Network surveillance policy and the Public Hospitals Act, we request that you provide us with the following information to ensure your patient meets our immunization and TB requirements for persons carrying on activities in a hospital environment.

Please complete:

TB Skin Test History			
TB Test 2 Step	<u>Step 1:</u> Date Planted:	<input type="checkbox"/> LFA <input type="checkbox"/> RFA	Date Read: Induration: mm Interpretation: POS NEG
	<u>Step 2:</u> Date Planted:	<input type="checkbox"/> LFA <input type="checkbox"/> RFA	Date Read: Induration: mm Interpretation: POS NEG
If TB 2-step record available 1-step TB result required within last 12 months:			
Date Planted:	<input type="checkbox"/> LFA <input type="checkbox"/> RFA	Date Read:	Induration: mm Interpretation: POS NEG
If there is a documented TB (+) result on file, NO TB test is required.			
Please provide: TB Test Result:		Date:	
If TB positive:			
Required - A copy of the CXR report; CXR should be within 1 year			
Result:		Date:	
Treatment for TB infection? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is this person free from Active TB? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date:			

Please see reverse side of page

Please complete the following immunization/history section and provide vaccine history

Immunization	Requirements		
Measles	Require proof of 2 measles-containing vaccines OR lab results indicating immunity		
Mumps	Require proof of 2 Mumps-containing vaccines or lab results indicating immunity		
Rubella	Require proof of 1 Rubella-containing vaccine OR lab results indicating immunity		
Varicella	Require proof of 2 Varicella-containing Vaccines or lab results indicating immunity		
Pertussis (Tdap)	Require proof of 1 Pertussis-containing vaccine. An adolescent requires routine booster dose. An adult, one additional booster dose		
Hepatitis B	Proof is not required for immunity to Hepatitis B, although it is recommended to follow up with your family doctor for immunization.		
Vaccine		Date	
MMR vaccine	1.	2.	
Varicella Vaccine	1.	2.	
Tdap Vaccine (Adacel/Boostrix)	Adolescent dose (17 years & under): Adult dose (18 years & up):		
TD Booster Date			
Titre Type	Date	Result	
		Immune	Non Immune
Measles Titre			
Mumps Titre			
Rubella Titre			
Varicella Titre			
Physician Signature:		Date:	
Physician Stamp:			
Please return to: Volunteer Services, Scarborough Health Network			
<input type="checkbox"/> Birchmount Hospital 1 st Floor – Volunteer Office 3030 Birchmount Rd.	<input type="checkbox"/> General Hospital Ground Floor – Volunteer Office 3050 Lawrence Ave E.	<input type="checkbox"/> Centenary Hospital Ground Floor – Volunteer Office 2867 Ellesmere Rd.	