SHN
SCARBOROUGH HEALTH NETWORK

Communicable Disease Health Screening

☐ Volunteer ☐ Spiritual Care Volunteer ☐ RMFR Volunteer ☐ Co-Op Student

Last Name: PLEASE PRINT CLEARLY	**First Name**: PLEASE PRINT CLEARLY
Date of Birth: DD/MM/YYYY	Gender: ☐ Male ☐ 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	Step 1: Date Planted:	☐ LFA ☐ RFA	Date Read:	Induration: mm Interpretation: POS NEG
	Step 2: Date Planted:	☐ LFA ☐ RFA	Date Read:	Induration: mm Interpretation: POS NEG
If TB 2-step record available 1-step TB result required within 12 months:				
Date Planted:	☐ LFA ☐ 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? ☐Yes ☐No Date:			Is this person free from Active TB? ☐Yes ☐No	

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		
COVID-19 Vaccine TWO doses **MANDATORY**	Vaccine #1 Date:	Vaccine #2 Date: Booster Date (if taken):

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

☐ **Birchmount Hospital**	☐ **General Hospital**	☐ **Centenary Hospital**

PLEASE PROVIDE ACCOMPANYING BLOOD WORK/CHEST X-RAY REPORT AND PROOF OF TWO COVID VACCINES

SHN