PROVIDENCE
Seward
Mountain Haven

Elder Name:_____
DOB: _____

Tuberculosis Screening

All individuals seeking admission to Providence Seward Mt. Haven must **be free of active signs and symptoms of Tuberculosis.** All individuals must have a CXR negative for findings of TB within 60 days of admission and have a negative screening for active signs and symptoms of TB *performed by either a RN or physician.*

___ **No History of Tuberculosis or Positive PPD**
___ **History of Positive PPD or Tuberculosis (Specify :_____)**
Chest X-Ray Completed on: _____ Result: _____

Has applicant had any of the following S/S during the past 1 year?	**No**	**Yes (provide dates)**
Cough greater than 3 weeks in duration		
Bloody Sputum		
Night Sweats		
Unexplained weight loss		
Unexplained fever		

If any signs and symptoms are answered "YES," notify the admissions office for further evaluation.

Inter-facility Infection Control Transfer Form

Name of Sending Facility: _____ Infection Control Contact: _____
Is the Elder currently receiving antibiotics? ___NO ___YES Specify: _____
Is the patient currently in isolation? ___NO ___YES Type of Isolation: _____

Does Elder currently have infection, colonization OR history of positive culture of multidrug-resistant organism (MDRO) or other organism of epidemiological significance?	**Colonization or History** (y/n)	**Active infection on treatment** (y/n)
Methicillin-resistant Staphylococcus aureus (MRSA)		
Vancomycin-resistant Enterococcus (VRE)		
Clostridium difficile		
E. Coli, Klebsiella, Proteus, etc w/Extended Spectrum B-Lactamase (ESBL)		
Other:		

Immunization Record

Vaccine	**Date (MM/DD/YYYY) Administered**	**Lot & Brand (if known)**
Influenza (seasonal)		
Pneumococcal 13 (step 1 of 2)		
Pneumococcal 23 (step 2 of 2)		
Zoster		
Tetanus, Diphtheria, Pertussis		
Other:		
Other:		

_____
Signature of RN or MD completing form **Date**

_____
Printed name of RN or MD completing form