Pre-biologic treatment Checklist

Patient Name: ..... **Today's date:** .....

Date of Birth: ..... **MRN:** .....

Physician/ Nurse: ..... **Diagnosis:** .....

Previous therapy (if applicable): ..... **Proposed biologic treatment:** .....

Other medication(s): .....

Medical History			**Comments**
Demyelinating disease in person or family, i.e. first-degree relative (e.g. MS: optic neuritis)	**Y**	**N**	
Signs and symptoms of active TB Past H/O TB or close family member contact with active TB	**Y** **Y**	**N** **N**	
H/O Hep B, Hep C, HIV	**Y**	**N**	
H/O allergies (e.g. latex, egg)	**Y**	**N**	
Past history of malignancy (except NMSC)	**Y**	**N**	
H/O cardiac failure	**Y**	**N**	
H/O heavy smoking (>20/day)	**Y**	**N**	
Planned surgery (if yes, follow guidelines)	**Y**	**N**	
Contraception (if relevant, follow guidelines)	**Y**	**N**	
Immunosuppression in last 3 months	**Y**	**N**	

Vaccination and Screening			**Comments**
H/O BCG vaccination	**Y**	**N**	
Recommend pre-treatment vaccinations (if serology -ve and delay acceptable)			
• Influenza	**Y**	**N**	
• Pneumococcal	**Y**	**N**	
• Varicella zoster	**Y**	**N**	
Mammogram (if relevant)	**Y**	**N**	Date:
Last cervical smear (if relevant)	**Y**	**N**	Date:

Screening Investigations		Date	Results
TB Screening • CXR and tuberculin skin test (TST or Mantoux) if **NO** immunosuppression in last 3 months • CXR and IGRA (TB ELISpot/QuantiFERON®-TB gold test) if immunosuppressed • Refer **ALL** patients to local TB service with a H/O previously treated TB, or who have had close contact with a case of active TB	☐ ☐ ☐		
Bloods • FBC/ESR • Renal function • LFT • Hep B/Hep C • HIV • VZV serology • ANA/dsDNA • Fasting lipids/glucose	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		
• Urinalysis • Pregnancy test (if relevant)	☐ ☐		

Physician discussed side effects/patient leaflet with patient:	**Sign:**	**Date:**
Risk of infection, malignancy, demyelination: **Advise on avoiding live vaccines 2 weeks before, during and 6 months after**		
Consent of the patient:	**Sign:**	**Date:**