



照片
PHOTO

英国签证申请人结核筛查体检登记表

UK Pre-Departure Tuberculosis Screening Programme

姓名: 王小红 性别: 男 女 出生日期: 25/05/1995 (日/月/年)
 国籍: 中国 护照号码: G11111 护照有效期: 25/05/2020 签证类型: T4
 同行 11 岁以下儿童人数 (不含 11 岁): 0 电话号码: 13761111111
 中国居住地址 (请用英文填写): Room 201, Building 3, No. 15 Jinbang Rd, Shanghai
 英国联系地址 (请用英文填写): University of Southampton, University Rd, Southampton
 英国邮政编码: SO17 1BJ Hampshire, UK

● 请如实回答下列问题:

1. 您是否患过肺结核?	<input type="checkbox"/> 是 <input checked="" type="checkbox"/> 否
2. 您是否接受过抗结核治疗?	<input type="checkbox"/> 是 <input checked="" type="checkbox"/> 否
3. 在过去三个月内,您是否有以下症状:	<input type="checkbox"/> 是 <input checked="" type="checkbox"/> 否 <input type="checkbox"/> 发热 <input type="checkbox"/> 盗汗 <input type="checkbox"/> 慢性咳嗽 <input type="checkbox"/> 咯血 <input type="checkbox"/> 体重减轻
4. 过去两年内,您的家庭成员是否患过肺结核?	<input type="checkbox"/> 是 <input checked="" type="checkbox"/> 否
5. 您在近期是否接触过活动性肺结核患者?	<input type="checkbox"/> 是 <input checked="" type="checkbox"/> 否
6. 针对女性,您目前是否怀孕?	<input type="checkbox"/> 是 <input checked="" type="checkbox"/> 否 最近一次月经: <u>25/05/2017</u>
7. 针对儿童,您的孩子是否存在以下情况:	<input type="checkbox"/> 慢性呼吸系统疾病 (如囊性纤维化) <input type="checkbox"/> 紫绀 <input type="checkbox"/> 呼吸功能不全,活动受限 <input type="checkbox"/> 胸部手术史

▶▶▶▶▶ 请仔细阅读表格反面《知情同意书》并签字确认。

受理医生 Physician	胸片检查 X-ray	出证医生 Diagnosis	申请人确认取走证书 Acknowledge Receipt of Certificate	特殊情况备注 Remarks



申请人申明:

本人已了解下述情况:

- 在申请入境英国前,我必须接受肺结核筛查(X光检查),并可能进一步接受痰液检查;
- 如果胸部X光检查发现异常,医师将对我进行单独询问并告知我进一步检查的步骤;
- 如果我的胸部X光检查结果为异常,无论是新发病灶或陈旧病灶,只要该病变提示结核可能,或者存在其他临床表现提示结核可疑,我都必须提供三次痰液标本供结核菌涂片和培养检测。痰培养检查结果需10周时间,我对此表示接受。
- 如果需要进行痰液检查,我应在胸部X光检查后7天内返回进行留痰,采痰需在连续3天早晨进行。如果不能在7天内返回留痰,我将无法获得签证用“医学证明”。
- 如果痰涂片或培养显示有结核杆菌存在,我须接受抗结核治疗,治疗费用将由我自行承担。我还应告知承担抗结核治疗的医疗机构,与我密切接触的家庭成员可能需要进行相关的结核病评估。
- 我有权拒绝接受结核病筛查或抗结核治疗,但该行为可能影响申请赴英签证。
- 医务人员对于是否给予医学证明具有最终决定权,我对此表示接受。

女性申请人:

所有的女性申请人都将被询问末次月经日期,以便确定是否妊娠。

- 如果我已怀孕,以下几个检查方案可供我选择:(1)在佩戴铅保护裙后进行胸部X光检查;(2)将胸部X光检查(和结核病筛查)推迟到分娩后再进行;(3)连续留三次痰液标本用于实验室检查。
- 我已了解:胸部X光检查对胎儿可能存在危害,但该风险在妊娠第二、第三个阶段非常低。在接受胸部X光检查前,我可以就相关风险问题咨询主诊医生或妇产科医生。一旦我决定接受X光检查,所有风险将由我自行承担。

本人谨申明如下:

- 同意接受结核病的相关检测;
- 授权贵方及贵方指定的实验室保存检测过程中收集的所有相关个人信息,包括医疗记录和胸部X光片;
- 授权贵方和贵方指定的场所与英国移民当局、英国卫生部、英国健康保护署和英国国家医疗保健服务系统,共享我的个人信息和评估结果;
- 如果我所居住国法律有要求,授权贵方将我的检测结果告知该国卫生部门;
- 英国政府及贵方对于结核病评估过程和评估结果可能对我造成的一切损失、伤害或其它损害不承担任何责任。

本人已阅读了《知情同意书》,并已就其中疑问部分咨询医师,本人在此声明接受同意书中内容。

申请人签名
姓名(正楷)

王小红
王小红

日期

15/6/2017

对于儿童或无心智能力签署《知情同意书》的成人: 本人系申请人的父母或法定监护人,接受同意书中内容。
对于不能亲笔签署《知情同意书》的成人: 本人系独立见证人,申请人已经口头同意或经其它非语言形式接受同意书中内容。

签名

与申请人的关系

姓名(正楷)

日期

译者声明(如果需要):

本人已尽我所能,以申请人能理解的形式为其翻译《知情同意书》中内容。

签名

姓名(正楷)

日期

对于存在妊娠可能的女性签证申请人:

本人确认已了解孕期进行胸部X线检查的相关风险,本人希望进行胸部X线检查。

签名

姓名(正楷)

日期

医务人员声明(如果需要):

本人已将知情同意书内容告知申请人,申请人拒绝接受上述筛查。

签名

姓名(正楷)

日期



英国签证申请人结核筛查体检登记表

UK Pre-Departure Tuberculosis Screening Programme

Given name: WANG Family name: Xiaohong Gender: Male Female Date of Birth: 25/05/1995
 Nationality: Chinese Passport No: G11111 Passport Validity: 25/05/2020 Visa Category: T4
 Number of accompanying children under 11: 0 Telephone No: 13761111111
 Full residential address: Room 201, Building 3, No. 15 Jinbang Rd, Shanghai, China.
 Address in the UK: University of Southampton, University Rd, Southampton, Hampshire
 Postcode in the UK: SO17 1BJ

● Please answer the following questions

1. Have you ever diagnosed from tuberculosis?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
2. Have you ever received anti-TB treatment?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
3. In the last 12 months, do you suffer from:	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Cough <input type="checkbox"/> Haemoptysis <input type="checkbox"/> Weight loss
4. Has your family member suffered from TB?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
5. Have you contacted any active TB patient?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
6. For female applicant, are you pregnant? :	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Last menstrual period: <u>25/05/2017</u>
7. For children under 11 years old:	<input type="checkbox"/> Chronic respiratory disease (e.g. Cystic fibrosis) <input type="checkbox"/> Cyanosis <input type="checkbox"/> Respiratory insufficient that limits activity <input type="checkbox"/> Thoracic surgery



Please read and sign the Informed Consent Form on the back.

受理医生 Physician	胸片检查 X-ray	出证医生 Diagnosis	申请人确认取走证书 Acknowledge Receipt of Certificate	特殊情况备注 Remarks



Applicant's Declaration:

I understand that:

- I am required to undergo testing for pulmonary tuberculosis (TB), involving an X-ray and possibly sputum tests, prior to applying for clearance to go to the UK;
- If my chest X-ray is abnormal, I will receive individual counselling and an explanation of the further testing procedures.
- If my chest X-ray is abnormal, and changes are suggestive of tuberculosis, regardless of whether these changes are old or new, or if there are other clinical reasons to suspect TB, I will have to provide three sputum samples which will be tested for TB with smear and culture. I understand that the results of sputum cultures may take up to ten weeks
- If sputum samples are necessary, I will be required to return for sputum collection on three consecutive mornings starting within seven days of my chest X-ray. If I fail to return within seven days, I will forfeit the opportunity to obtain a TB Certificate.
- If the smear or culture shows the presence of TB bacteria, I will be referred for TB treatment. Treatment shall be at my own expense. I will inform the TB treatment facility that I have close family contacts, who may need evaluation for TB.
- I have the right to refuse to undergo the TB assessment procedure and TB treatment, but accept such a refusal may adversely impact my UK visa application.
- I understand that the physician has the final decision about whether I receive a Certificate

Female applicants.

All female applicants will be asked about their last menstrual period to identify applicants who possibly may be pregnant:

- If I could be pregnant, I will be offered several alternatives; 1) a chest X-ray with protective shield; 2) I can postpone the CXR (and clearance) until after delivery or 3) I can choose to provide three sputum samples for laboratory examination.
- I acknowledge that a CXR can carry a risk for the unborn child, but that this risk is quite small in the second and third trimester. I therefore advise to consult the panel physician and may wish to consult my gynaecologist to understand the risks before I take a chest X-ray. If I decide to submit for an X-ray, this shall be at my own risk.

I hereby

- consent to undergo testing;
- authorise you and your designated laboratory to store all relevant personal information collected during the assessment process including health records and chest X-ray;
- authorise you and your designated clinics to share my personal details and assessment results with the UK immigration authorities, UK Department of Health, Public Health England and the UK National Health Service.
- I authorise you to share my assessment results with the health authorities of my country of residence, where this is required by country's laws.

I have read this consent form, or had it translated for me. I was invited to ask questions to clarify what was not clear to me. I understand the content of this declaration.

Applicant's signature *[Signature]* Date *25/05/2017*

For children, or adults without the mental capacity to give consent, I confirm that I am the parent or legal guardian of the applicant and confirm that I give my consent

For adults who are not able to physically sign the form, I confirm that I am an independent witness and the applicant has given their consent orally or by other non-verbal means

Signature _____ Date _____
Relationship to applicant _____

Statement of interpreter (if required); I have translated the content of this document for the applicant to the best of my ability and in a way in which I believe s/he can understand.

Signature _____ Date _____

For female applicants who might be pregnant; I confirm that I have had the risks of having a chest X-ray in pregnancy explained to me and I wish to carry on with the chest X-ray.

Signature _____ Date _____

Statement of Physician (if required); I have explained the content of this document to the applicant and confirm that the applicant has declined to go ahead with the assessment.

Signature _____ Date _____