HEALTH

DOCUMENTS

TUBERCULOSIS SCREENING QUESTIONNAIRE

SIGNAL HEALTH GROUP OF RALEIGH

EMPLOYEE INFORMATION:

PRINT NAME: _____

SIGNATURE: _____ **DATE COMPLETING FORM:** _____

EARLY DETECTION OF TUBERCULOSIS: This questionnaire gives guidance in identifying individuals with suspected or confirmed TB so that appropriate controls can be promptly initiated.

AGENCY REP INSTRUCTIONS:

- Check each answer provided by the employee and add your comments as the evaluator.
- Institute AMS exposure control measures outlined in AMS Exposure Control Plan, Respiratory Protection and Medical Surveillance Program and refer the individual for further evaluation if the individual has:
    1. A persistent cough lasting 3 or more weeks and two or more symptoms of active TB.
    2. Had a positive TB test on mucous that he/she coughed up.
    3. Been told that he/she had TB and was treated, but never finished the medication.

TB HISTORY (Part 1)

1. Have you ever had a positive TB skin test? ☐ YES ☐ NO ☐ DON'T KNOW

2. Have you ever had an abnormal chest X-Ray? ☐ YES ☐ NO ☐ DON'T KNOW
If yes, how long ago? _____

3. Have you recently had the mucous you cough up tested for TB? ☐ YES ☐ NO ☐ DON'T KNOW

If yes, were you told it was positive? _____

4. Have you ever been told you have Infectious Tuberculosis? ☐ YES ☐ NO ☐ DON'T KNOW

5. If yes, how long ago? _____

6. Have you ever been treated with medication for Infectious Tuberculosis? ☐ YES ☐ NO ☐ DON'T KNOW

7. Do you live with or have you been in close contact with someone who was recently diagnosed with TB?
(ie: shelter roommate, close friend, relative) ☐ YES ☐ NO ☐ DON'T KNOW

CURRENT SYMPTOMS (Part 2)

1. Do you have a cough that has lasted longer than three weeks? ☐ YES ☐ NO

2. Do you cough up blood or mucous? ☐ YES ☐ NO

3. Have you lost your appetite? Aren't hungry? ☐ YES ☐ NO

4. Have you lost weight (more than 10 lbs) in the last 2 months without trying to? ☐ YES ☐ NO

5. Do you have night sweats (need to change the sheets or your clothes because they are wet?) ☐ YES ☐ NO

EVALUATOR COMMENTS: _____

_____

REFERRED FOR FURTHER EVALUATION? ☐ YES ☐ NO

EVALUATOR'S SIGNATURE/TITLE: _____ DATE: _____

AGENCY 2 STEP TB RESULTS

NAME: _____

STEP 1:

Mantoux test site: ☐ Right Forearm ☐ Left Forearm ☐ Other _____

Lot #: _____ Expiration Date: _____ Size of wheel _____mm

Administered by: _____ Date & Time: _____

Read by: _____ Date & Time: _____

Induration: _____mm

STEP 2:

Mantoux test site: ☐ Right Forearm ☐ Left Forearm ☐ Other _____

Lot #: _____ Expiration Date: _____ Size of wheel _____mm

Administered by: _____ Date & Time: _____

Read by: _____ Date & Time: _____

Induration: _____mm

HEPATITIS B VACCINE ACCEPTANCE / DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring the Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated with the vaccine, at no charge to me. The series consists of 3 doses: an initial IM dose, a 2nd dose 30 days after and a 3rd dose at 6 months.

PLEASE CHECK **ONE** OF THE FOLLOWING:

☐ **I DECLINE HEPATITIS B SERIES:**

I DECLINE THAT VACCINATION AT THIS TIME

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me. OSHA [56 FR 64004, Dec. 06, 1991, as amended at 57 FR 12717, April 13, 1992; 57 FR 29206, July 1, 1992; 61 FR 5507, Feb. 13, 1996]

☐ **I DECLINE as I have previously received the vaccine series on:** _____

_____ _____

Employee Signature **Date**

☐ **I CONSENT TO HEPATITIS B VACCINE:**

I hereby consent to the administration of the Hepatitis B vaccine series and understand this will be at no charge to me. I know that I should not take this series if I am pregnant or nursing. I also understand that I should not take the vaccine if I have active infection present or have an allergy to the compound. I understand the risks and side effects of the injections and release the Agency from any liability that may arise from the effects of the vaccine.

BY SIGNING MY NAME BELOW, I AM STATING THAT I DO WISH TO HAVE THE HEPATITIS B VACCINE. I UNDERSTAND THAT THIS IS THREE (3) INJECTIONS AND THAT I MUST RECEIVE ALL INJECTIONS TO BE CONSIDERED VACCINATED AGAINST HBV INFECTION. I AGREE TO FOLLOW THROUGH ON ALL 3 VACCINES.

_____ _____

Employee Signature **Date**

SIGNAL HEALTH GROUP OF RALEIGH

7421 Brighton Village Dr
Raleigh, NC 27616
P: 518.491.8624 F:

EMPLOYEE HEALTH STATEMENT

Employee/Applicant

NAME: _____ DOB: _____

STATEMENT OF HEALTH

To be completed by Health Professional

I have examined the individual named above and to the best of my knowledge, he/she is in good physical and mental health, free of any communicable diseases and is able to function in his/her profession at full capacity.

By signing below, I certify that the above information is true and correct.

HEALTH PROFESSIONAL NAME (PRINTED): _____

SIGNATURE: _____

OFFICE PHONE NUMBER: _____

DATE OF OFFICE VISIT: _____

OFFICE ADDRESS: _____

_____

_____

DRUG SCREEN POLICY

POLICY:

Each employee of the Agency will participate in pre-employment drug screening, reasonable suspicion drug screening, incident/accident screening and participate in the annual drug screening program.

GUIDELINE:

PRE-SCREEN

- A minimum of a six (6) panel test will be used which will include: amphetamines, methampetamines, cocaine, marijuana, opiates and PCP.
- All potential employees will be provided with a copy of the drug policy, sign a written consent and submit to pre-employment drug testing.
- No potential employee will have contact with patient until they can successfully pass a drug test and/or provided current prescription information from the prescribing Dr. for medications which would show in testing.
- If the potential employee test are positive, they are ineligible for hire.
- The potential employee is welcome to reapply in six (6) months.

REASONABLE SUSPICION – CURRENT EMPLOYEE

- When cases of reasonable suspicion occur, the employee will be contacted and
    - Immediately suspend staff pending results.
    - Sign a second written consent.
    - Receive a minimum of a six (6) panel test.
    - Provide any current prescription information from the prescribing Dr. for medications which would show in testing.

INCIDENT / ACCIDENT TESTING – CURRENT EMPLOYEE

- When an employee completes an Incident/Accident form to report possible injury resulting from work or is in an automobile accident the employee will
    - Sign a second written consent.
    - Receive a minimum of a six (6) panel test.
    - Provide any current prescription information from the prescribing Dr. for medications which would show in testing.

RANDOM DRUG TESTING – ALL EMPLOYEES

- Human Resource and/or managememt will be responsible for the Random Drug Testing Program. Random Drug Testing is at the discretion of management.

POSITIVE TEST RESULTS

- If an employee's test results are positive, the test must be verified by a confirmation test. The employee shall pay for the confirmation test.
- If the confirmation test verifies a positive result, the employee will:
    - Be discharged or suspended from direct patient care for at least six (6) months.
    - After six (6) months, re-testing will occur.
        - If positive test occurs at that point as well as a confirmation test; termination.
        - If negative test is obtained, patient contact can resume with quarterly testing to occur for one (1) year.

EMPLOYEE SIGNATURE: _____

EMPLOYEE PRINTED NAME: _____

DATE: _____