Volunteer Employee Health Initial Screening

North Central Baptist Hospital

Last Name: ______________________________ First Name: ________________________________

Age/Date of Birth; _____________________________ Social Security #: _______________________

Mailing Address: ____

City/State/Zip: ____

Home Phone: ____

Signature: ____ Date: __________________

EMPLOYEE HEALTH MEDICAL STATUS/HISTORY

____

Print: Name Date

Please CIRCLE the correct response for any of the following conditions you currently have or had in the past. If YES, give explanation in the space provided:

YES NO >HEART DISEASE: ____
YES NO >BLOOD PRESSURE PROBLEMS (HIGH/LOW): __________________________
YES NO >CIRCULATION/BLOOD PROBLEMS:_____________________________
YES NO >STROKE: ____
YES NO >LUNG/BREATHING PROBLEMS: ______________________________
YES NO >TUBERCULOSIS (SELF/CLOSE CONTACT): _________________________
YES NO >HEPATITIS: ____
YES NO >KIDNEY/URINARY PROBLEMS: ______________________________
YES NO >DIABETES (IINSULIN/NON-INSULIN): ___________________________
YES NO >LOW BLOOD SUGAR: ____
YES NO >NERVOUS SYSTEM/NEUROLOGICAL PROBLEMS: ______________________
YES NO >SEIZURES/EPILEPSY: ____
YES NO >CANCER: ____
YES NO >SURGERY: ____
YES NO >SKIN ALLERGIES/SENSITIVITIES: ______________________________
YES NO >MENTAL ILLNESS/DISORDER: _________________________________
YES NO >VISION OR HEARING PROBLEMS: ______________________________
YES NO >MUSCULAR PROBLEMS: _____________________________________
YES NO >ORTHOPEDIC PROBLEMS: ____________________________________
YES NO >GASTROINTESTINAL/DIGESTIVE PROBLEMS: _______________________
YES NO >ANY OTHER MEDICAL CONDITIONS: ____________________________
YES NO >SMOKE CIGARETTES/CIGARS (IF YES, HOW MUCH): __________________

YES NO >DO YOU HAVE ANY PRIOR OR EXISTING WORKERS COMPENSATION CLAIMS WITH A FORMER OR CURRENT EMPLOYER? __________________________
____

YES NO >DO YOU HAVE ANY MEDICAL CONDITIONS THAT WOULD RESTRICT OR LIMIT YOUR ABILITY TO PERFORM THE ESSENTIAL FUNCTIONS OF THE POSITION FOR WHICH YOU HAVE APPLIED OR ARE CURRENTLY PERFORMING? _____________
____

LIST CURRENT MEDICATIONS (Prescription & Over the Counter) DOSAGE REASON
____
____
____
____

COMMENTS: ____
____
____

I verify that the preceding information is true, correct and complete.
I understand that any false, incomplete, or omitted information may result in rejection of my employment or in Termination when discovered. I understand this form will be part of my confidential employee health record.

____

EMPLOYEE SIGNATURE DATE EMP # OR SS#

[ ] New Hire [ ] Two Step
[ ] Annual [ ] Volunteer/Student/Physician
[ ] Exposure [ ] Other: ___________________________

EMPLOYEE HEALTH TUBERCULOSIS SCREENING

Please Print:

____

Name: Last, First, MI Employee # or SS #

____

Department / Shift Extension # Age / Date of Birth

PLEASE CHECK THE CORRECT ANSWER AND FILL IN THE BLANKS AS NEEDED:

		YES	**NO**
1.	Have you ever been diagnosed with the disease Tuberculosis? If YES, give dates/age:		
2.	Have you ever had a POSITIVE Tuberculin skin test reaction or POSTIVE TB Blood test? If YES, date of test and last chest x-ray:		
3.	Have you ever taken anti-tuberculin drugs? If YES, how long did you take these drugs and when:		
4.	Have you ever been given the BCG Tuberculin vaccine? If YES, when:		
5.	Was your last Tuberculin skin test / TB Blood test NEGATIVE (0 MM induration – no reaction)? Date of last PPD Tuberculin skin test:		
6.	Have you taken any medications containing cortisone/steroids in the past month? If YES, please explain:		
7.	Have you had any vaccinations in the past 6 weeks? If YES, type and date:		
8.	Have you had any health changes in the past year? If YES, please explain:		
9.	Are you immunocompromised, immunosuppressed or have any autoimmune disorder/condition? (Cancer, Organ transplant, HIV, Lupus, etc.) If YES, please explain:		
10.	Do you have any of the following signs/symptoms of Tuberculosis? (If YES, check which ones) [ ] Unexplained cough that lasts more than 3 weeks [ ] Loss of Appetite [ ] Coughing up blood in the sputum [ ] Night Sweats [ ] Persistent Fatigue, Exhaustion [ ] Unexplained Weight Loss [ ] Hoarseness		

I CONFIRM THAT THE ABOVE ANSWERS ARE CORRECT. IF HAVING A TB SKIN TEST, I WILL RETURN 2-3 DAYS (48-72 HOURS) AFTER INJECTION TO HAVE THE TEST READ BY AN APPROVED PPD READER.

____

SIGNATURE (PARENT/GUARDIAN IF UNDER 18 YRS OLD) PRINT NAME DATE

Date/Time Given	PPD Test Name	Dose & Site	Given by	Lot #	Expiration Date	Date Read	Result (circle)	Read by/Title (comments)
___/____/___ ____ : _____ AM / PM	Tubersol	0.1 ml 5 US (TU) LFA / RFA					0 MM NEG Positive _______MM Questionable	
___/____/___ ____ : _____ AM / PM	Tubersol	0.1 ml 5 US (TU) LFA / RFA					0 MM NEG Positive _______MM Questionable	

INFORMATION ABOUT MYCOBACTERIUM TUBERCULOSIS (M.Tb) AND TUBERCULIN SKIN TESTING:

When you receive a Mantoux/Purified Protein Derivative (PPD) tuberculin skin test, it is to determine if you have been exposed/infected with M.Tb. This germ can affect all areas of the body, but the diagnosis that is of most importance is tuberculosis of the lungs or larynx, also called pulmonary tuberculosis. This type of M.Tb can be transmitted to others by talking, singing, coughing, sneezing.
The signs/symptoms of pulmonary tuberculosis are listed on the front in question #10.

A POSITIVE PPD tuberculin skin test result indicates that you have probably been exposed to tuberculosis. Of those who have a positive Tb skin test reaction, 90% will never develop clinical M.Tb and they not considered infectious. Of those 10% who do develop clinical M.Tb, 50% wilt develop the disease within the first 2 years after the exposure. This is why it is important that appropriate Tb screening tests be done in a timely manner per Centers for Disease Control (CDC) recommendations.

- Positive PPD = 10mm or more of induration at the injection site. Individuals with a positive Tb skin test but a negative chest x-ray are not infectious and may work.
- A Tb skin test result of 5mm induration is classified as a positive result in individuals who are: *Immunocompromised (HIV, cancer, organ transplants),
  *Close contacts of persons with infectious Tb (family members, roommates, etc),
  *Have chest x-rays that suggest old Tb and have not received adequate treatment, *Injectable drug abusers.

If you have been identified as having had a positive tuberculin (Tb) skin test in the past, or you can't do annual tuberculin skin tests due to allergy or other medical condition, we are required every year to notw you of the signs and symptoms of tuberculosis, document if you have any signs/symptoms and what to do if you develop any of these signs/symptoms.

A NEGATIVE PPD tuberculin skin test result indicates that you probably have not been exposed/infected with M.Tb.

For new BHS employees/students, a PPD test will need to be done if they do not have proof of one in the last 3 months. If they have not had a Tb skin test in the last 12 months, a second skin test — called the 2 Step Method — will be done 1-3 weeks after the first PPD as long as the first test was negative.

- Negative PPD = 0-4mm or no induration at site of injection. This indicates no infection with Tb is present.

The Tine test is a multiple-puncture type of Tb skin test. It is much less accurate that the PPD test and therefore is not accepted by the Texas Dept. of Health (TDH), CDC or BHS.

BCG (Bacille Calmette-Guerin) vaccine is given to prevent M. Tb- It is rarely used in the United States but has been used in many other countries. The vaccine's effectiveness is unreliable. . Persons with a history of having had BCG vaccine may have a reaction to the Tb skin test. The PPD Tb skin test should be given if there is a history of BCG vaccination but no history of a positive Tb skin test.

Cortisone or corticosteroids taken by mouth or injection within the tast 4 weeks can cause an unreliable PPD result. Topical agents and/or inhalants do not affect test results.

Measles, Mumps, Rubella, Varicella (chickenpox), or Smallpox vaccines given within 4 weeks of the Tb skin test can result in a false negative reading.

The TB Skin Test is not contra-indicated during pregnancy/breast feeding. If the individual and/or their physician do not want the individual to receive the Tb skin test, we will need documentation stating such from the treating MD.

NORTH CENTRAL BAPTIST HOSPITAL
Passionate people. Compassionate care.

Name:_____________________________________ Date of Birth: _____________ Department/Ext: ________________

Employee Number: ____________________________ EMAIL: ____

[ ] 6 month review for Employee [ ] Annual Review for Volunteers

Signs & Symptoms of Tuberculosis

[ ] Yes [ ] No Have you lost unexplainable weight in the last 6 months without dieting? If yes, how much? _________
[ ] Yes [ ] No Are you experiencing a loss of appetite: If yes, how long? ______________________________________
[ ] Yes [ ] No Do you on a regular basis have unexplainable night sweats or wake up with the sheets wet from sweating? If yes, how long? __________________
[ ] Yes [ ] No Do you have a frequent persistent cough? If yes, how long? __________________
[ ] Yes [ ] No Are you bothered by being tired all of the time? If yes, how long? __________________
[ ] Yes [ ] No Are you bothered by shortness of breath? If yes, how long? __________________
[ ] Yes [ ] No Do you cough up blood? If yes, how long? __________________
[ ] Yes [ ] No Have you been having increased temperature? If yes, how long? __________________

Medical History

[ ] Yes [ ] No Have you ever had a positive TB Skin or blood test? If yes, what year? _______________
[ ] Yes [ ] No Have you ever taken medication to prevent or treat TB, e.g., isoniazid (INH) or rifampin?
[ ] Yes [ ] No Have you ever had the BCG vaccine? If yes, year ______________
[ ] Yes [ ] No Have you ever had TB disease diagnosis? If yes, year ________________
[ ] Yes [ ] No Have you had a live virus vaccine in the past 4 week? If yes, wait 4 weeks.
[ ] Yes [ ] No Have you had a recent viral illness? If yes, wait 2 weeks.
[ ] Yes [ ] No Are you taking immunosuppressive drugs? If yes, consider 5 mm positive.
[ ] Yes [ ] No Do you have any health conditions or take medications that might affect your immune system (e.g., steroids, HIV/AIDS, organ transplant, chemotherapy, severe chronic illness)? If yes, consider 5 mm positive.

Travel History

[ ] Yes [ ] No Were you born in the US? If no, where? _________________ When did you come to the US? _____________
[ ] Yes [ ] No Since your last screening, have you traveled outside the country? When / where / how long? ______________

I understand if I should experience any of the signs and symptoms of tuberculosis above at any time during the year, I will contact Occupational Health immediately. I understand if the TB test reaction is not read in 48 to 72 hours after its administration, it will have to be repeated. By signing this form I consent to receive a Tuberculin Skin Test, to comply with employment requirement.

Employee Signature: ____Date: __________________

Employee Health Nurse Signature: *D. Parra RN*______ Date: _____________

***Below is for Office use only **

I understand if I should experience any of the signs and symptoms of tuberculosis above at any time during the year, I will contact Occupational Health immediately.

______ Reviewed and provided a copy of the TB Signs/Symptoms Educational Handout to Employee