



**HEALTH  
DOCUMENTS**

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# TUBERCULOSIS SCREENING QUESTIONNAIRE

SIGNAL HEALTH GROUP, INC.

## 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?<br>If yes, how long ago? _____   | YES | NO | DON'T KNOW |
| 3. Have you recently had the mucous you cough up tested for TB?<br>If yes, were you told it was positive? _____  | YES | NO | DON'T KNOW |
| 4. Have you ever been told you have Infectious Tuberculosis?<br>5. If yes, how long ago? _____   | YES | NO | DON'T KNOW |
| 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?<br>(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 2<sup>nd</sup> dose 30 days after and a 3<sup>rd</sup> 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:** \_\_\_\_\_

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**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.**

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**Employee Signature**

**Date**

**SIGNAL HEALTH GROUP**

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P: 800.260.6145 F: 888.681.9011

**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, methamphetamines, 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 management 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: \_\_\_\_\_