E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
PRE-PLACEMENT TUBERCULOSIS HISTORY AND EVIDENCE OF IMMUNITY

☞ See GENERAL INSTRUCTIONS on last page.

FOR NON-DHS/NON-COUNTY WFM

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E or C#:
E-MAIL ADDRESS:	**HOME/CELL PHONE #:**	**DHS FACILITY:**	**DEPT/WORK AREA/UNIT:**
JOB CLASSIFICATION: Medical Student	**NAME OF SCHOOL/EMPLOYER/AGENCY/SELF:** DGSOM at UCLA	**AGENCY CONTACT PERSON:** Mimi Vuong	**AGENCY PHONE #:** 310-267-1104

In accordance with Los Angeles County, Department of Health Services policy 705.001, Title 22, and CDC guidelines all contactors/students/volunteers working at the health facilities must be screened for communicable diseases prior to assignment. This form must be signed by a healthcare provider attesting all information is true and accurate OR workforce member may supply all required source documents to DHS Employee Health Services to verify.

SECTION 1: FOR WORKFORCE MEMBER TO COMPLETE

TUBERCULOSIS SYMPTOM REVIEW – Check all appropriate boxes

☐ No ☐ Yes Cough lasting more than 3 weeks	☐ No ☐ Yes Excessive fatigue/malaise
☐ No ☐ Yes Coughing up blood	☐ No ☐ Yes Recent unprotected close contact with a person with active TB
☐ No ☐ Yes Unexplained/unintended weight loss (> 5 LBS)	☐ No ☐ Yes A history of immune dysfunction or are you receiving chemotherapeutic or immunosuppressant agents
☐ No ☐ Yes Night sweats (not related to menopause)	
☐ No ☐ Yes Fever/chills	
☐ No ☐ Yes Excessive sputum	Allergies: ☐ No Known Allergies ☐ Yes:

If you have any of the above symptoms, you should meet with your provider to determine whether a chest x-ray is indicated.

SECTION 2: FOR HEALTHCARE PROVIDER TO COMPLETE OR MUST PROVIDE SOURCE DOCUMENTS

A

TUBERCULIN SKIN TEST RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal
Must have 2 negative TST < 12 months of start date.

DATE PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS (Indicate: Reactor / Non-Reactor / Converter)
	1st								mm	
	2nd								mm	

If either result is positive, send for CXR and complete Section C below.

OR

B					
	Negative IGRA: QuantiFERON or Tspot (<12 months)	Date:	Results	☐ LA County ☐ Outside Document	**STATUS**

If CXR is positive for active TB, DO NOT CLEAR for hire/assignment.
Refer Workforce Member for immediate medical care.

C					
	Positive TST (no date requirement)	Date:	Results mm	☐ LA County ☐ Outside Document	**STATUS**
	CXR (at or after date of +TST)	Date:	Results _____	☐ LA County ☐ Outside Document	

OR

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D	Positive IGRA: QuantiFERON or Tspot (no date requirement)	Date:	Results _____	☐ LA County ☐ Outside Document	**STATUS**
	CXR (at or after date of +IGRA)	Date:	Results _____	☐ LA County ☐ Outside Document	

OR

E	History of Active TB with Treatment	Date:	__months with ___	☐ Outside Document	**STATUS**
	CXR (after date of completed Tx)	Date:	Results _____	☐ Outside Document	

OR

F	History of LTBI Treatment	Date:	__months with ___	☐ Outside Document	**STATUS**
	CXR (at or after date of Tx)	Date:	Results _____	☐ Outside Document	

AND

G

IMMUNIZATION DOCUMENTATION HISTORY (MANDATORY)

	Titer Result Date	Titer Result	If not immune, give Vaccination x 2, unless Rubella x 1		Date Received	Vaccine Received	Declined Vaccination (may be restricted from hospital/patient care)	
Measles		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ Decline only for true medical contraindication, must include medical documentation
Mumps		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ Decline only for true medical contraindication, must include medical documentation
Rubella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 1**			**OR**	☐ Decline only for true medical contraindication, must include medical documentation
Varicella		☐ Immune ☐ Non-Immune ☐ Equivocal ☐ Laboratory confirm of disease	**OR**	**X 2**			**OR**	☐ Decline only for true medical contraindication, must include medical documentation

AND

H

Vaccination	Date Received	Date of Declination Signed	
Tetanus-diphtheria (Td) every 10 years		**OR**	
Acellular Pertussis (Tdap) X 1			

AND

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I

Vaccination (MANDATORY to offer to WFM who have potential to be exposed to blood or body fluid)			**If not reactive, vaccinate with HepB series**	**Date**	**Vaccine**		☐ N/A (job duty does not involve blood or body fluid)
	Date	Titer	**AND**				**Date** _____ ☐ Declination signed
Hepatitis B Surface Ab Titer (HbsAb) anti-HBs		☐ Reactive ☐ Non-reactive	☐ 3 dose series (Engerix-B or Recombivax) Or ☐ 2 dose series (Heplisav-B)			**OR**	**Date** _____ **HbcAb/ anti-HBc** ☐ Non-reactive ☐ Reactive
							Date _____ **HbsAg** ☐ Non-reactive ☐ Reactive

AND

J

Vaccination	**Date Received**	**Facility Received**	**OR**	**Date Declination Signed**
Seasonal Influenza (one dose for current season)				**Note:** Must wear mask during influenza season.

J1

Vaccination (Provide copy)	**Date Received**	**Manufacturer**	**Lot**	**OR**	**Date of future appointment**	**OR**	☐ **Not Vaccinated**
COVID Vaccine 1st dose				**OR**		**OR**	☐ **Not Vaccinated**
2nd dose							

AND

K

Respiratory Fit Testing (Must be < 12 months from annual date)

Date: **Passed on:** ☐ N95 Honeywell DF300 Standard ☐ Halyard 46827/76827 Small ☐ N95 Halyard 46727/76727 Regular ☐ Maxair PAPR 700 ☐ Maxair CAPR DLC36 ☐ N/A (Job duty does not involve airborne precautions or require a respirator)

L

Color Vision (MANDATORY for WFM working with point of care testing)	Date:	☐ **Pass** ☐ **Fail** ☑ **N/A** (Job duty does not involve POC testing or electrical)

FOR HEALTHCARE PROVIDER: ☐ I attest that all dates and immunizations listed above are correct and accurate.		
Date:	Physician or Licensed Healthcare Professional Signature:	Print Name:
Facility Name/Address:		Phone #:

OR

FOR WORKFORCE MEMBER: ☑ Required source documents attached.	
Workforce Member Signature:	Date:

DHS-EHS STAFF ONLY		
☐ WFM completed pre-placement health evaluation.		Date of clearance:
Signature:	Print Name:	Today's Date:

LAST NAME	FIRST, MIDDLE NAME	BIRTHDATE	E or C#

SECTION	☞ GENERAL INSTRUCTIONS FOR EACH SECTION
	TUBERCULOSIS DOCUMENTATION HISTORY **ALL WORKFORCE MEMBER (WFM) SHALL BE SCREENED FOR TB UPON HIRE/ASSIGNMENT**
A	WFM shall receive a baseline TB screening using two-step Tuberculin Skin Test (TST). Step 1: Administer TST test, with reading in seven days. Step 2: After Step 1 reading is negative, administer TST test, with reading within 48-72 hours. If both readings are negative, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually. a. Documentation of negative TST within 12 months prior to placement will be accepted. WFM shall receive a one-step TST with reading within 48-72 hours. If result is negative, WFM is cleared to work. b. Documentation of negative two-step TST within 12 months prior to placement will be accepted. WFM is cleared to work. If TST is positive, record results and continue to Section C.
B	WFM shall receive a baseline TB screening using a single blood assay for M. tuberculosis (IGRA). If negative result, WFM is cleared to work. WFM shall receive either TST or IGRA and symptom screening annually. a. Documentation of negative IGRA within 12 months will be accepted. WFM is cleared to work. If IGRA is positive, record results and continue to Section D.
	TST POSITIVE RESULTS **If CHEST X-RAY IS POSITIVE, <u>DO NOT CLEAR</u> FOR HIRE/ASSIGNMENT, AND** **REFER WORKFORCE MEMBER FOR IMMEDIATE MEDICAL CARE**
C	If TST is positive during testing in Section A or C above, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR at or after first positive TST will be accepted for clearance to work as long as TB symptom screening is negative.
D	If IGRA is positive during testing in Section D above, send for a CXR. If CXR is negative, WMF is cleared to work. Documentation of negative CXR at or after first positive IGRA will be accepted for clearance to work as long as TB symptom screening is negative.
E	If WFM have a documented history of active TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR < 12 months of start date will be accepted for clearance to work as long as TB symptom screening is negative. If documentation is supported, WFM is cleared to work.
F	If WFM have a documented history of latent tuberculosis infection (LTBI) treatment TB, send for a chest x-ray (CXR). If CXR is negative, WFM is cleared to work. Documentation of negative CXR after LTBI treatment will be accepted for clearance to work as long as TB symptom screening is negative.
	IMMUNIZATION DOCUMENTATION HISTORY Documentation of immunization or adequate titers will be accepted. If WFM is not immune against communicable diseases as listed in this section, WFM shall be immunized (unless medically contraindicated). WFM who declines the vaccination(s) must sign the mandatory declination form. WFM who declines the vaccination(s) may be restricted from patient care areas of the hospital or facility. If WFM is non-immune or decides at a later date to accept the vaccination, DHS or WFM contract agency will make the vaccination available.
G	Documentation of laboratory evidence of immunity or laboratory confirmation of disease will be accepted **OR** documentation of two doses (live measles, mumps and varicella) and one dose of live rubella virus vaccine. Measles vaccine shall be administered no earlier than one month (minimum 28 days) after the first dose. Mumps second dose vaccine varies depending on state or local requirements. Varicella doses shall be at least 4 weeks between doses for WFM. If Equivocal, WFM needs either vaccination or re-draw with positive titer. **DHS-EHS must be notified if WFM does not demonstrate evidence of immunity.**
H	**<u>Td</u>** – After primary vaccination, Td booster is recommended every 10 years. If unvaccinated WFM, primary vaccination consists of 3 doses of Td; 4-6 weeks should separate the first and second doses; the third dose should be administered 6-12 months after the second dose. **Tdap** should replace a one-time dose of Td for HCP aged 11 and up.
I	All WFM who have occupational exposure to blood or other potentially infectious materials shall have a documented post vaccination antibody to Hepatitis B virus, HBsAb (anti-HBs). Hepatitis B vaccine series is available to WFM. Non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to HBsAg positive blood.
J	Seasonal influenza vaccine is offered annually to WFM when the vaccine becomes available.
J1	COVID-19 vaccine (e.g. Pfizer 2-dose series separated by 21 days or Moderna 2-dose series separated by 28 days) is offered to WFM. (Provide copy)
	RESPIRATORY FIT TEST
K	If WFM job assignment requires a N95 respirator, WFM must be fit tested for the N95 respirator. If WFM job assignment involves Airborne Infection Isolation Rooms (AIIR), WFM will need to be fit tested. Include manufacture, model and size of N95 WFM passed fit testing on.
	COLOR VISION
L	If WFM job assignment involves Point-of-Care testing or electrical duties, WFM will need to be tested for Color Vision (Mandatory for WFM working with Point-of-Care testing)

This form and its attachment(s), if any, such as medical records shall be maintained and filed at non-DHS/non-County workforce member's School/Employer. The School/Employer shall verify completeness of DHS-Employee Health Services (EHS) form(s) and ensure confidentiality of non-DHS/non-County WFM health information.

Upon request by DHS-EHS, the non-DHS/non-County WFM School/Employer shall have this form and its attachment(s) readily available within four (4) hours.

All workforce member health records are confidential in accordance with federal, state and regulatory requirements.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. 29 C.F.R. Part 1635