HEALTH SCREEN INSTRUCTIONS

CREDENTIALED PROFESSIONAL STAFF, RESIDENTS, CLINICAL FELLOWS and VISITING ELECTIVES

Welcome to St. Joseph's Health Care London (St. Joseph's)! As part of your Medical Affairs onboarding process, Occupational Health and Safety Services (OHSS) requires all Credentialed Professional Staff, Residents, Clinical Fellows and Visiting Electives to complete a pre-placement health assessment before their starting date.

Submission

Completed Pre-Placement Health Assessments are submitted to: ohsshealthreviews@sjhc.london.on.ca All documents must be submitted in **English** and in **PDF** format.

Immunization Requirements

All Credentialed Professional Staff, Residents, Clinical Fellows and Visiting Electives must provide **proof** of the following **minimum requirements** in pdf format:

- ☐ Two (2) Varicella vaccinations or lab-confirmed proof of immunity
- ☐ Two (2) Measles, Mumps and Rubella vaccinations or lab-confirmed proof of immunity
- ☐ Annual seasonal Influenza vaccine
- ☐ Hepatitis B serology

Credentialed Professional Staff, Residents, Clinical Fellows and Visiting Electives who decline vaccinations may require work restrictions and/or a work accommodation. Work accommodation is based on the relevant exposure risks, and subject to the hospital's ability to accommodate.

Tuberculosis (TB) Surveillance Requirements

All Credentialed Professional Staff, Residents, Clinical Fellows and Visiting Electives must meet the requirements for TB surveillance at St. Joseph's. These include:

- ☐ Proof of 2 step TB skin test **OR** recent or historical positive TB skin test **(greater than 10 mm of induration)**
- ☐ Annual TB skin test **IF** two (2) step was completed greater than 12 months ago.
- ☐ A chest X-ray is only required if the TB skin test is positive. Refer to **Section C – Tuberculosis Questionnaire**

BCG vaccination, QuantiFERON-TB Gold/IGRA serology do not preclude the requirement of a TB skin test.

Serology

Credentialed Professional Staff, Residents, Clinical Fellows, and Visiting Electives who perform exposure-prone procedures have an ethical responsibility to know their serological status for Hepatitis B Virus, Hepatitis C Virus and Human Immunodeficiency Virus (HIV). Those who learn they are infected should seek advice from their professional regulatory body. OHSS can advise on recommended safe work practices.

N95 Fit Testing

Fit testing for an N95 particulate respirator is required every two (2) years for all Credentialed Professional Staff, Residents, Clinical Fellows and Visiting Electives.

Pertinent Health History

Credentialed Professional Staff, Residents, Clinical Fellows and Visiting Electives should provide information about allergies, health conditions, and accommodation requirements to OHSS.

Recommended Immunizations

The following immunizations are not required, but are recommended for all Credentialed Professional Staff, Residents, Clinical Fellow, and Visiting Electives:

- ☐ Hepatitis B
- ☐ Tetanus, Diphtheria, Pertussis (Tdap)
- ☐ Meningitis (roles that involve likely contact with n. meningitidis)
- ☐ COVID-19 (KP.2)

HEALTH SCREEN FORM – SECTION A

Start Date Click or tap to enter a date.

Past St. Joseph's Record ☐ Yes ☐ No

Last Name ____________________

First Name ____________________

Gender ☐ Male ☐ Non-Binary ☐ Female ☐ Prefer Not to Say

Date of Birth Click or tap to enter a date.

College Registration Number (CPSO, RCDSO, CMO or CNO) ____________________

Emergency Contact ____________________

Contact's Phone Number ____________________

☐ **Professional Staff** ☐ **Resident** ☐ **Clinical Fellow** ☐ **Visiting Elective**

Department ____________________

Leader's Name ____________________

PERTINENT HEALTH INFORMATION

Do you have any allergies or health conditions that you feel OHSS should be aware of?

☐ Yes ☐ No

If Yes, provide details below

Do you have limitations/restrictions, or a disability that requires an accommodation or ergonomic adjustment in the workplace?

☐ Yes ☐ No

If Yes, provide details below

N95 MASK FIT TEST

If you have not had an N95 Fit Test in the past two (2) years, you may register for a test through your ME (My Education) account. You will require your corporate ID which will be emailed to you prior to your starting date at St. Joseph's.

N95 Fit Test Date Click or tap to enter a date. **Mask Size** ____________________

Send a copy of the N95 Fit Test Record to: N95FitTesting@lhsc.on.ca

HEALTH SCREEN FORM – SECTION B – REQUIRED IMMUNIZATIONS OR PROOF OF IMMUNITY

Please provide proof of vaccination OR serology reports demonstrating immunity.
Please provide all documents in English and pdf format.

Measles, Mumps and Rubella (MMR)		
Requirement	*Date*	*Immunity*
MMR # 1	Click or tap to enter a date.	
MMR # 2	Click or tap to enter a date.	
Measles Serology	Click or tap to enter a date.	☐ Yes ☐ No
Mumps Serology	Click or tap to enter a date.	☐ Yes ☐ No
Rubella Serology	Click or tap to enter a date.	☐ Yes ☐ No

Varicella		
Requirement	*Date*	*Immunity*
Varicella # 1	Click or tap to enter a date.	
Varicella # 2	Click or tap to enter a date.	
Varicella Serology	Click or tap to enter a date.	☐ Yes ☐ No

Hepatitis B		
Requirement	*Date*	*Immunity*
Anti-HBs	Click or tap to enter a date.	☐ Yes ☐ No

Seasonal Influenza		
Requirement	*Date*	*Brand*
Proof of Vaccination for Current Influenza Season	Click or tap to enter a date.	

Tuberculosis Surveillance			
Requirement	*Date Planted*	*Date Read*	*Induration Level*
Step 1	Click or tap to enter a date.	Click or tap to enter a date.	
Step 2	Click or tap to enter a date.	Click or tap to enter a date.	
Annual (as applicable)	Click or tap to enter a date.	Click or tap to enter a date.	
Positive TB Skin Test ⟶	Complete Sections C and D		

Recommended Immunizations

Please attach proof of the following recommended immunizations, if applicable:

☐ Hepatitis B series and booster (if applicable)
☐ Tetanus, Diphtheria and Pertussis vaccination
☐ Meningitis vaccination (contact with n. meningitidis only)
☐ COVID-19 (KP.2)

Serology

Please attach proof of the following:

☐ Hepatitis B surface antibody (Anti-HBs)

Attestation:

I attest that the information provided on this form is true and complete. I understand that all private health information is confidential and shall not be released to any source internally or externally without my consent. I understand that Occupational Health and Safety Services will maintain my health information and will comply with the St. Joseph's Confidentiality Policy.

______________________	______________________	______________________
Printed Name	**Signature**	**Date (MM/DD/YYY)**

HEALTH REVIEW FORM – SECTION C – POSITIVE TUBERCULOSIS (TB) SKIN TEST QUESTIONNAIRE

A TB Skin Test is considered positive if the level of induration (firm swelling**) is greater than or equal to 10 mm***

Positive TB Skin Test

Click or tap to enter a date.	Click or tap to enter a date.	
Date Planted	Date Read	Induration Level

Chest X-Ray

Must be completed following the date the TB skin test was read

Click or tap to enter a date.	☐ Normal ☐ Abnormal
Date	Result

If Abnormal Check all that apply

☐ Fibronodular Disease ☐ Granulomata ☐ Calcified Granulomata
☐ Evidence of active TB ☐ Evidence of past TB infection
☐ Other - ______________________________

Relevant History

☐ History of active TB disease
☐ Unprotected TB exposures in previous year

History of symptoms of active TB in previous year:
☐ No symptoms
☐ Productive cough ☐ Blood in Sputum ☐ Chest Pain
☐ Shortness of Breath ☐ Fever ☐ Fatigue
☐ Night Sweats ☐ Unexplained weight loss

Risk Factors for Developing Active TB
☐ HIV ☐ TNF ☐ Diabetes
☐ Smoke ☐ Organ Transplant ☐ BMI < 20
☐ Silicosis ☐ Tx with glucocorticoids

BCG Vaccination

Have you received BCG vaccination?
☐ No
☐ Yes Date Click or tap to enter a date.
☐ Less than two (2) years of age
☐ Two (2) years of age or older

Immigration History

Country of Birth	
State, Province or Territory (if applicable)	
Date of Arrival in Canada	Click or tap to enter a date.
Age at Arrival in Canada (years)	

Travel History

Please list of Countries you have visited in the last 12 months regardless of duration or purpose.

Medical Follow Up

Check all that apply:

☐ Have reviewed positive TB skin test with a medical practitioner
☐ QuantiFERON-TB Gold or IGRA serology completed

Click or tap to enter a date. ☐ Normal ☐ Abnormal

Date Result

☐ Treated for active or Latent TB Infection (LTBI)

Click or tap to enter a date.

Date Completed

I would like to talk to Health and Safety Nurse to receive further education, investigation and/or treatment regarding my positive TB testing:

☐ Yes ☐ No

**A TB skin test can be considered positive if induration is greater than or equal to 5 mm if the following criteria are met:*

- *HIV infection*
- *Contact with infectious TB in the past two (2) years*
- *Fibronodular disease on chest X-ray*
- *Organ transplant*
- *Treatment with TNF alpha inhibitors*
- *Treatment with immunosuppressive drugs (equivalent to 15 mg/day of Prednisone for one (1) month or more)*
- *End stage renal disease*

HEALTH REVIEW FORM – SECTION D – POSITIVE TUBERCULOSIS (TB) SKIN TEST EDUCATION AND ATTESTATION

Latent TB Infection (LTBI)

A positive TB skin test (TST), in the absence of evidence of active TB, is most often attributed to Latent TB Infection (LTBI).

BCG Vaccination

BCG vaccination is rarely the reason for a positive TB skin test in adulthood. For those who have only received one BCG vaccination, it is estimated that only 1% of those given BCG as an infant will have a TB skin test after 10 years of age. Therefore, if you have had one BCG vaccination as an infant, then your positive TB skin test result is likely a true positive. The positive predictive value of your TB skin test can be calculated by using the Online TST/IGRA Interpreter (tstin3d.com)

Monitoring for Signs and Symptoms of Active TB

Individuals with LTBI may progress to active TB during periods of immunosuppression, even with a normal chest x-ray. There is an approximate 5% lifetime cumulative risk of reactivation to an acute (active) TB infection. Signs and symptoms of active TB infection include a progressively worsening cough lasting > 3 weeks, hemoptysis, chest pain, shortness of breath, fever, night sweats and unexplained weight loss.

Additional Testing and Assessment

Repeating TB skin tests are medically contraindicated and should be avoided. Severe localized and blistering reactions can occur if a TB skin Test is given after having a positive test. There is also no clinical value in performing a TST in the future once a test is considered positive.

Chest X-rays for the purpose of surveillance following a normal chest x-ray are not required.

QuantiFERON -TB gold serology test is an option to determine if my TB skin test is a true or false positive. This test is not covered by OHIP and can be ordered through primary care providers or Health and Safety Nurse.

A referral to an Infectious Disease Specialist to discuss the risk of developing active TB and treatment for LTBI can be arranged through primary care providers or the Health and Safety Nurse.

Attestation

I attest that I have reviewed the above information and understand that a Health and Safety Nurse may contact me if further information is required to provide clearance to practice at St. Joseph's related to TB. I understand that I am responsible for monitoring signs and symptoms of active TB and will seek out medical attention, refrain from attending work at St. Joseph's in person, and contact OHSS if these symptoms occur. I attest that the information provided on the TB Questionnaire is true and complete.

____________________	____________________	____________________
Printed Name	**Signature**	**Date** (MM/DD/YYY)