# CITY-WIDE HEALTH SCREEN FOR VISITING ELECTIVES

| | | |
|---|---|---|
| **Anticipated Start Date of Clinical Placement (YYYY/MM/DD):** | | |
| **Anticipated End Date of Clinical Placement (YYYY/MM/DD):** | | |
| **First Name:** | | **Last Name:** |
| **Gender:** | **Date of Birth (YYYY/MM/DD):** | **Family Physician:** |
| **Phone:** | | **Email:** |
| **Emergency Contact Person:** | | **Contact's Phone:** |
| **Primary Hospital Affiliation:** ☐ **LHSC** ☐ **SJHC** | | |
| **Department:** | | **Division:** |
| **Role:** ☐ **Professional Staff** ☐ **Resident** ☐ **Clinical Fellow** | | |
| **Past LHSC Record:** ☐ **Yes** ☐ **No** **Past SJHC Record:** ☐ **Yes** ☐ **No** | | |

A Health Screen is an integral part of your hospital appointment and **must** be completed prior to your start date. The required/recommended immunizations or proof of immunity and TB testing may be obtained at your family physician/primary care office, local health unit, or community clinic.

Visiting Elective Physicians 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. For those with no regulatory body, the local Medical Officer of Health or OHSS can provide advice with respect to recommended safe work practices.

**Prior to your anticipated start date,** return this completed form with **PROOF** of immunizations/immunity to Occupational Health and Safety Services (OHSS) at Victoria Hospital. OHSS will contact you if any requirements are outstanding.

Visiting Elective Physicians who decline vaccinations may require work restrictions and/or a work accommodation. Work accommodations are based on the relevant exposure risks, and subject to the hospital's ability to accommodate**.**

**For further information and answers to common questions, please go to the link:**
https://www.sjhc.london.on.ca/medical-affairs/resources/health-review

**Submit completed Health Screens and Supporting Documentation to:**

London Health Sciences Centre
Victoria Hospital
Occupational Health and Safety Services, Rm E1-505
800 Commissioners Road East, London, ON
N6A 5W9
519-685-8500 ext. 52286
**Fax: 519-685-8374**
**Email:** OHSS-medicalaffairs@lhsc.on.ca

## REQUIRED VACCINATIONS

**Red Measles**

You require 2 doses of measles containing vaccine with the first dose being given on or after your 1st birthday and the second dose given at least 4 weeks from the first dose OR laboratory evidence of immunity.

**Rubella**

You require 1 dose of rubella containing vaccine, given on or after your 1st birthday OR laboratory evidence of immunity.

**Mumps**

You require 2 doses of mumps containing vaccine with the first dose being given on or after your 1st birthday and the second dose given at least 4 weeks from the first dose OR laboratory evidence of immunity.

**Varicella** (Chicken pox)

You require documented receipt of 2 doses of varicella vaccine (e.g., physician's certificate or vaccination record) OR laboratory evidence of varicella immunity, or laboratory confirmation of disease. Immunization is required for those without immunity.

**Influenza** (flu)

Seasonal influenza vaccination, or completion of an attestation form is required. LHSC and SJHC offer onsite influenza vaccination during the influenza season.

## RECOMMENDED VACCINATIONS

**Hepatitis B**

It is recommended that all health care workers receive a course of Hepatitis B vaccine. For your protection, it is important to obtain a Hepatitis B antibody titre following immunization to ensure that you are adequately protected. If you have been vaccinated, please provide laboratory evidence of immunity.

**Tetanus/Diphtheria/Pertussis (Tdap)**

A one-time dose of Tetanus/Diphtheria and Acellular Pertussis booster is recommended regardless of the date of your last Tetanus/Diphtheria vaccination. Those who are providing care to pregnant women and/or children should receive a Tdap as soon as possible.

**Tetanus/Diphtheria**

It is recommended that you receive a primary series of Tetanus/Diphtheria in childhood followed by a routine booster every ten (10) years.

**COVID -19**

Vaccination for COVID-19 is highly recommended for all hospital employees, professional staff, residents and clinical fellows, and is offered via local COVID-19 Vaccination Clinic Sites

Important information about covid-19 vaccination & timing of other vaccinations:

*All vaccinations, including the Tuberculosis (TB) Skin Test should not be given within 14 days prior to, or 28 days following administration of a COVID-19 vaccine.*

**Meningitis:**

Vaccination for meningitis may be recommended if working in a microbiology laboratory where routine exposure to preparations of cultures of *N. meningitidis* are likely.

## TUBERCULOSIS (TB) SURVEILLANCE

### Tuberculosis (TB) Skin Test

You are required to have a baseline two-step TST regardless of BGC, unless you have:

- ➔ Documented results of a prior two-step test, OR
- ➔ Documentation of a negative TST within the last 12 months, in which case a single-step test may be given

***NOTE:*** IGRA results are not accepted as an alternative to the TB skin test. A baseline two-step TB skin test is a requirement in accordance with the Communicable Diseases Surveillance Protocols for Ontario Hospitals (OHA, 2018).

### Positive TB Skin Test

A chest X-ray and associated report is required and must be completed after the documented date of a positive TB skin test, or if there is a history of active TB disease. The chest X-ray results will be reviewed by the Occupational Health Physician/ Nurse Practitioner in order to rule out active disease. Another chest x-ray may be taken if clinically indicated. Consultation with a medical provider regarding a positive TB skin test is highly recommended. If you have not received counseling or advice concerning prophylactic treatment, you may be referred for an expert consultation. If you have already received counseling or advice concerning prophylactic treatment, please provide a copy of your consult note.

## N95 FIT TESTING

Fit testing is required every 2 years for all health care workers who wear an N95 particulate respirator as part of their job duties, as directed by Ontario Health.

Have you been fit-tested within the last 2 years for an N95 respirator?

☐ Yes (Attach Fit Test Record)

☐ No → **Fit-Testing at LHSC and St. Joseph's:**

Registration for an N95 fit-test is done through your ME (MyEducation) account. To access your ME account, you will require your Corporate ID, which will be emailed to you prior to your hospital start date.

## PERTINENT HEALTH INFORMATION

Do you have any allergies or health conditions that you feel Occupational Health & Safety Services should be aware of? ☐ Yes -> If **Yes**, provide details below ☐ No

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

☐ Yes -> If **Yes**, provide details below ☐ No

## IMMUNIZATION HISTORY

Please complete the following immunization/history section. **Proof of immunization/immunity** is required and may include the following documentation: official public health vaccine record, documentation from your physician/primary care provider, immunization history from previous employer or educational institution (must be signed by a physician/nurse), and laboratory reports. Please provide supporting documents in **English**.

**REQUIRED VACCINATIONS/PROOF OF IMMUNITY**

**Measles, Mumps, Rubella (MMR)Vaccination/Evidence of Immunity**
(If full series provided, evidence of immunity not required)

| | Date | Result | Immune Y/N |
|---|---|---|---|
| MMR 1 | | | |
| MMR 2 | | | |
| Measles Serology | | | |
| Mumps Serology | | | |
| Rubella Serology | | | |
| Measles, Mumps and Rubella administered separately (attach document with dates) | | | |

**VARICELLA Vaccination/Evidence of Immunity** (If full series provided, evidence of immunity not required)

| A self-reported history of chicken pox or shingles (herpes zoster) is not sufficient to demonstrate immunity. | Date | Result |
|---|---|---|
| Varicella 1 | | |
| Varicella 2 | | |
| Varicella Serology | | |

**INFLUENZA VACCINATION:**

| Provide date of most recent vaccination | Date: | Attach attestation if declining vacation |
|---|---|---|
| Influenza | | |

**RECOMMENDED VACCINATIONS**

**Hepatitis B Vaccination/Evidence of Immunity**

| Hepatitis B Vaccine | Date | Result: |
|---|---|---|
| 1st Hep B | | |
| 2nd Hep B | | |
| 3rd Hep B | | |
| Booster (if applicable) | | |
| Evidence of Immunity (HBsAb) | | |

Tetanus, Diphtheria, Acellular Pertussis (Tdap)Vaccination

| | Date: |
|---|---|
| Tdap | |
| Date of most recent Td (optional): | |

**COVID-19 Vaccination:**

| | Brand Name | Date: |
|---|---|---|
| COVID 19 #1 | | |
| COVID 19 #2 | | |

MENINGITIS Vaccine: (specific laboratory and pathology roles only)

| | Date: |
|---|---|
| Men-C-ACYW-135 | |
| 4CMenB | |

## TUBERCULOSIS (TB) SURVEILLANCE

**TB skin Test * Repeat TB Skin test is not required if positive in the past (> 10 mm of induration)**

| Test | Date Planted | Date Read | Result +/- | Level of Induration (mm) |
|---|---|---|---|---|
| 1st step | | | | |
| 2nd Step | | | | |
| Annual | | | | |
| Previous Positive TB Skin Test | | | | |

**Chest XRAY Required if TB Skin Test is Positive** ***Only 1 required after date of positive TB Skin Test**

| Date | Result (attach report) |
|---|---|
| | |

**Positive TB Skin TST or history of positive TB Skin Test/Active Infection:**

| **LHSC** | **ST Joseph's Health Care** |
|---|---|
| Please complete the<br><br>**TB Questionnaire**<br>**&**<br>**LHSC Medical Affairs Tuberculosis Education Agreement**<br><br>located at:<br><br>Medical Affairs Health Screen Forms | **Answer the following additional Questions:**<br><br>1. Have you consulted with a medical practitioner or Infectious Diseases Specialist about your positive TB Skin test?<br><br>☐ Yes → Attach documentation if available<br><br>☐ No<br><br>2. Have you travelled to endemic areas?<br><br>☐ Yes ☐ No |

All information received is strictly confidential. **It will be shared between Occupational Health departments at LHSC and St. Joseph's to complete health screen requirements**, and will reside at the Occupational Health department of the organization Medical Affairs deems to be your place of primary appointment.

Signature: Date:_____

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