E/E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
ANNUAL HEALTH QUESTIONNAIRE AND SCREENING

FOR DHS WORKFORCE MEMBER

GENERAL INFORMATION on Page 3

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E/C #:
JOB CLASSIFICATION:	DEPT #/PAY LOC:	WORK AREA/UNIT:	
EMAIL ADDRESS:	WORK PHONE:	NAME OF SCHOOL/EMPLOYER/AGENCY/SELF:	

In accordance with Los Angeles County, Department of Health Services policy 705.000 and 705.001, Title 22, and CDC guidelines all contactors/students/volunteers working at the health facilities must be screened for communicable diseases annually. 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.

Specialty Exam: ☐ Asbestos ☐ Antineoplastic/Hazardous Drugs ☐ DOT ☐ High Hazard Procedure (PAPR/CAPR) ☐ Respirator Fit Test (N95, ½ or full face) ☐ Hearing Conservation ☐ Other:______________________

FOR COMPLETION BY WORKFORCE MEMBER

TUBERCULOSIS (TB) RISK FACTORS – Check any of the following that apply to you.

☐ Do you work as a Respiratory Therapist?
☐ Are you likely to perform aerosol generating procedures (e.g. cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, sputum induction)?
☐ Do you work routinely in the Emergency Room (face to face contact with patients)?
☐ Do you perform autopsies?
☐ Do you work inside the secure areas of Correctional Health Services/Jail Wards?
☐ Do you work in microbiology lab (e.g. AFB bench)?
☐ Do you work routinely at the pre-triage/routing desk?
☐ Do you perform upper GI Endoscopy?
☐ Do you perform pulmonary function tests?

If you checked any of the questions above, a TB screening is REQUIRED.

TUBERCULOSIS (TB) SCREENING HISTORY – Answer the question(s) below.

☐ No ☐ Yes Do you have a history of a positive TB skin test or TB blood test?

If YES, did you take treatment for Latent TB Infection (LTBI) to prevent progression to active disease?
☐ Yes
☐ No → Treatment for LTBI is strongly encouraged, speak to your healthcare provider regarding short treatment regimens.

TUBERCULOSIS (TB) SYMPTOM REVIEW – Check any of the conditions you have had since your last health evaluation.

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

If you answered "YES" to any of the boxed questions above, a TB screening is REQUIRED.

RESPIRATOR USE SCREENING

☐ No ☐ Yes Do your job duties require you to use a N95, PAPR/CAPR, or greater respirator?
☐ No ☐ Yes Do your job duties require you to enter airborne precaution rooms?

If you answered "YES" to any of the questions above, a Respirator Fit Test (RFT) is REQUIRED.

ANNUAL TUBERCULOSIS (TB) EDUCATION

Log on to TalentWorks and complete the Annual Tuberculosis (TB) Education module to complete this requirement.

WORKFORCE MEMBER ACKNOWLEDGMENT

The answers to the questions contained in this questionnaire are to the best of my knowledge. I understand that this annual health questionnaire does not take the place of regular visits to a personal, primary care physician.

- ✓ This is to acknowledge that I am aware of handling antineoplastic/hazardous drugs may lead to acute effects such as skin rash, chronic effects including adverse reproductive events, and possibly cancer.
- ✓ This is to acknowledge that I have received and read DHS Policy #392.3 Hand Hygiene in Healthcare Settings policy and agree to comply with this policy as written. If I violate the Hand Hygiene policy, I will be subject to disciplinary action up to and including warning, reprimand, suspension and/or discharge from County employment.
- ✓ This is to acknowledge that I am aware that I am required to successfully complete annual Tuberculosis (TB) education in TalentWorks.
- ✓ This is to acknowledge that I can request Tuberculosis (TB) screening at any time by reporting to Employee Health Services.

Workforce Member Signature/eSig:_________________________________ **Date/Time:** ______________________

E/E2

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E/C #:

FOR COMPLETION BY EMPLOYEE HEALTH STAFF – OR – HEALTH CARE PROVIDER

TUBERCULOSIS (TB) HISTORY/SCREENING

☐ Positive TB Symptom Review with Clinical Evaluation
☐ Sent for CXR: ______________(Date)
CXR Results: ______________________________
Remove from duty: ☐ No ☐ Yes____________(Date)

History of Positive ☐ TST or ☐ IGRA
History of BCG ☐ No ☐ Yes
History of TB/LTBI Tx ☐ No ☐ Yes
TB/LTBI Treatment: ______________X_________months

TUBERCULIN SKIN TEST (TST) RECORD
0.1 ml of 5 tuberculin units (TU) purified protein derivative (PPD) antigen intradermal

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS Indicate: ➢ Reactor ➢Non-Reactor ➢Converter
	ANNUAL								mm	
	REPEAT								mm	

OR

DATE DRAWN	IGRA (TB Blood Test)	DATE RESULTED	(INITIAL)	RESULT	STATUS
	☐ QuantiFERON-TB Gold Plus (QFT-Plus) or ☐ T-SPOT				

NEW CONVERSION	CXR DATE	CXR RESULT	TREATMENT
☐ Latent TB Infection ☐ ACTIVE DISEASE → must remove from duty			☐ NO ☐ YES DATE STARTED TREATMENT: ____________

ANNUAL INFLUENZA STATUS (Provide Copy) - if declining, must wear a mask starting November 1st (Season is typically from July-April)

Date Received:	Facility Received At:	OR	Date Declined:	Reason for declination:
				☐ Medical Contraindication ☐ Religious Belief System ☐ Other: ______________

CURRENT FORMULA COVID-19 Vaccine STATUS (Provide Copy) - if declining, must wear mask during respiratory virus season.

Date Received:	Manufacturer:	Lot #:	OR	Date Declined:	Reason for declination:
					☐ Medical Contraindication ☐ Religious Belief System ☐ Other: ______________

RESPIRATOR FIT TESTING

Date:

Passed on: ☐ N95 Honeywell DF300 Standard ☐ N95 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)

EDUCATION/REFERRAL INFORMATION

☐ Reviewed immunization history and declination status
☐ Recommended annual exam with Primary Care Provider
☐ Referred to primary care provider for current issue: ______________________________
☐ Referred to EHS Provider for positive findings: ______________________________
☐ If LTBI without treatment, strongly encourage treatment, including short regimen
☐ Provided letter for LTBI treatment evaluation
☐ If declining LTBI treatment, obtain signed declination

COMMENTS

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____
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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 and Address:		Phone Number:

OR

FOR WORKFORCE MEMBER:
☐ **Required source documents attached.**

Workforce Member Signature:	Date:

DHS-EHS STAFF ONLY

☐ Workforce member completed annual health evaluation.	Date cleared by DHS-EHS:
Name of EHS Staff:	Date:

LAST NAME:	FIRST, MIDDLE NAME:	BIRTHDATE:	E/C #:

GENERAL INFORMATION

Workforce member (WFM) must complete health screening annually by the end of the month of last health screening. Annual health surveillance shall be performed to ascertain that WFM is free from infectious disease and is able to perform their assigned duties.

The health screening consists of:

1. Tuberculosis (TB) Risk Factors and Screening
2. Respiratory Fit Testing, if needed
3. Review of immunizations and provide recommended immunizations as needed, or obtain declination forms for declined immunizations

Annual health screening will be provided to County workforce members (WFM) and volunteers at no charge. Non-County WFM and students must obtain health screening from their physician or other licensed healthcare professional (PLHCP) or school, as applicable; and provide DHS Employee Health Services (EHS) a health screening clearance certificate (E2- Annual Health Questionnaire and Screening) including supporting documentation(s) as applicable. Consent must be obtained from minor's parent or legal responsible person to obtain health records. Health screening for contract staff will be provided in accordance with the terms of the contract. Fees and costs for these services shall be billed to the contractor as appropriate.

No person will be allowed to work inside County medical facility without documentation of health clearance or required health screening.

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

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

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

DHS-EHS will obtain the workforce member's written authorization before using or disclosing health information, include to self, unless the disclosure is required by State or Federal law such as to a public health authority or governmental regulatory agency.

Workforce members have the right to access their medical records and obtain a copy, thereof, within fifteen (15) days after the request.

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