E/E2

Health Services
LOS ANGELES COUNTY

EMPLOYEE HEALTH SERVICES
ANNUAL HEALTH QUESTIONNAIRE AND SCREENING

GENERAL INFORMATION on Page 3

FOR DHS WORKFORCE MEMBER

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:** _____

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

STATUS
Indicate:
➢ Reactor
➢ Non-Reactor
➢ Converter

DATED PLACED	STEP	MANUFACTURER	LOT #	EXP	SITE	*ADM BY (INITIALS)	DATE READ	*READ BY (INITIALS)	RESULT	STATUS
	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

_____
_____
_____

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: