

## GUIDELINES FOR COMPLETION OF CITY-WIDE HEALTH SCREEN FOR PROFESSIONAL STAFF/RESIDENTS/CLINICAL FELLOWS

**(MUST Provide Proof)**

Past LHSC/St. Joseph's Record: ☐ Yes ☐ No

|                                                                        |                             |                                                          |  |
|------------------------------------------------------------------------|-----------------------------|----------------------------------------------------------|--|
| Anticipated Start Date of Clinical Placement (YYYY/MM/DD):             |                             |                                                          |  |
| Anticipated End Date of Clinical Placement (YYYY/MM/DD):               |                             |                                                          |  |
| Please check off the appropriate category that you will be working in: |                             |                                                          |  |
| <input type="checkbox"/> Professional Staff                            |                             | <input type="checkbox"/> Resident                        |  |
|                                                                        |                             | <input type="checkbox"/> Clinical Fellow                 |  |
| First Name:                                                            |                             | Last Name:                                               |  |
| Gender:                                                                | Date of Birth (YYYY/MM/DD): | Family Physician:                                        |  |
| Home Phone:                                                            | Cell Phone:                 | Email:                                                   |  |
| Emergency Contact Person:                                              |                             | Contact's Phone:                                         |  |
| Primary Hospital Affiliation:                                          |                             |                                                          |  |
| <input type="checkbox"/> LHSC <input type="checkbox"/> SJHC            |                             |                                                          |  |
| Department:                                                            |                             | Division:                                                |  |
| Do you have any <u>food or drug/vaccine allergies</u> ?                |                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| If yes, provide details: _____                                         |                             |                                                          |  |

A Health Screen is an integral part of your hospital appointment and **must** be completed prior to your start date. The required/recommended vaccinations and TB testing may be administered at your family physician's office, the local health unit in the area which you reside or Occupational Health and Safety Services (OHSS).

LHSC clinical fellows and professional staff are directed to send their completed form with proof of immunizations/testing to the Victoria Hospital Occupational Health, Room E1-402 at LHSC. St. Joseph's clinical fellows and professional staff are directed to send their completed form with proof of immunizations/testing to the St. Joseph's Hospital Occupational Health location. Residents are directed to send their completed form with proof of immunizations/testing to the Victoria Hospital Occupational Health, Room E1-402 at LHSC.

**For further information and answers to common questions, please go to the link:**

<https://www.sjhc.london.on.ca/medical-affairs/resources/health-review>

All professional staff/residents/clinical fellows must attend any required OHSS appointments and/or complete recommended testing in a timely fashion.

Professional staff/residents/clinical fellows 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.

**Any professional staff/residents/clinical fellow who is unwilling or unable to be vaccinated 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.**

### Vaccination Recommendations/Requirements

#### 1. Red Measles

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

#### 2. Rubella

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

#### 3. Mumps

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

#### 4. 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 recommended for those without immunity.

#### 5. 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. If you have not already received a primary Tetanus/Diphtheria series, then you require three doses as part of an adult primary immunization regimen and should contact your family physician or Health Unit in order to complete your primary series.

#### 6. Tetanus/Diphtheria/Pertussis (Tdap)

It is recommended that you receive a one-time dose of Tetanus/Diphtheria and Acellular Pertussis booster. If you are providing care to pregnant women and/or children, you should receive this one-time dose of Tdap as soon as possible.

#### 7. 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 report of your antiHbs level.

### Tuberculosis (TB) Surveillance and Isoniazid (INH)

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 (taken from the Tuberculosis Surveillance Protocol for Ontario Hospitals 2018)

#### **Please submit records of all past and most recent TB skin tests.**

Please indicate in the box on page 4 if you have recently travelled to a TB Endemic area.

**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.

#### Individuals with Positive TB Skin Tests

A chest X-ray is required if there is a previously documented positive TB skin test or history of active TB disease. You must have documentation of chest X-ray taken after a positive TB skin test. In the event that you do not have a chest X-ray, you will be given a requisition and asked to complete the X-ray. These 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.

If you have a history of a confirmed positive TB test and 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, you should provide a copy of your consult note.

TB positive individuals, who are completing their primary placement/appointment at St. Joseph's, please complete the screening questions within the TB positive section of the attached City Wide Health Screen Form.

**TB Positive individuals, who are completing their primary placement/appointment at LHSC, please complete LHSC TB Positive Questionnaire, in addition to the TB positive section of the attached City Wide Health Screen Form.**

<https://www.sjhc.london.on.ca/medical-affairs/resources/health-review>

# CITY-WIDE HEALTH SCREEN FORM FOR ALL PROFESSIONAL STAFF/RESIDENTS/CLINICAL FELLOWS

## N95 Fit Testing

Fit Testing is required every two years. If you have been fit tested to one of the following N95 respirators within the last two years, additional fit testing is not required at this time. However, you will need to provide proof of your current fit testing record along with your immunization requirements.

• 3M model 1870/9210

• 3M model 8210

• 3M model 1860S

**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.

## Please complete the following immunization / history section (MUST Provide Proof)

### Proof of immunization is required and includes any of the following:

- Vaccination records from yellow immunization cards
- Immigration records
- Notes from physician's offices
- Copies of laboratory reports (titres)
- Health Unit records
- Other hospital electronic immunization records (provided they are signed by a physician or nurse)

| Immunization                                     | Requirements                                                                                                                                                                                                                                                                                 | Vaccine/Titre Type                      | Date<br>yyyy/mm/dd | Result               |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------|----------------------|
| Red Measles                                      | Require proof of 2 Red Measles-containing vaccines <u>OR</u> lab results indicating immunity                                                                                                                                                                                                 | MMR Vaccine (Measles / Mumps / Rubella) | 1.                 |                      |
|                                                  |                                                                                                                                                                                                                                                                                              |                                         | 2.                 |                      |
| Mumps                                            | Require proof of 2 Mumps-containing vaccines <u>OR</u> lab results indicating immunity                                                                                                                                                                                                       | Red Measles only Vaccine                |                    |                      |
| Rubella                                          | Require proof of 1 Rubella-containing vaccine <u>OR</u> lab results indicating immunity                                                                                                                                                                                                      | Red Measles Titre                       |                    |                      |
|                                                  |                                                                                                                                                                                                                                                                                              | Mumps Titre                             |                    |                      |
|                                                  |                                                                                                                                                                                                                                                                                              | Rubella Titre                           |                    |                      |
|                                                  |                                                                                                                                                                                                                                                                                              |                                         |                    |                      |
| Immunization                                     | Requirements                                                                                                                                                                                                                                                                                 | Vaccine Type                            | Date of Vaccine    | Titre<br>Date Result |
| Varicella (Chicken pox)                          | Require proof of 2 doses of Varicella vaccine at least 4 weeks apart <u>OR</u> laboratory evidence of immunity or laboratory confirmation of disease                                                                                                                                         | Varicella                               | 1.                 |                      |
|                                                  |                                                                                                                                                                                                                                                                                              |                                         | 2.                 |                      |
| Hepatitis B Vaccination                          | Strongly recommend vaccination/ laboratory confirmed immunity                                                                                                                                                                                                                                | Hepatitis B                             | 1.                 |                      |
|                                                  |                                                                                                                                                                                                                                                                                              |                                         | 2.                 |                      |
|                                                  |                                                                                                                                                                                                                                                                                              |                                         | 3.                 |                      |
| Tetanus, Diphtheria, Acellular Pertussis Td/Tdap | Td is recommended every 10 years. A one-time dose of Tdap (Adacel/Boostrix) is recommended as an adult. This can be given at any time, even if 10 years has not elapsed since your last Td. For those looking after pregnant women and children, a dose should be given as soon as possible. | Tetanus/Diphtheria (Td)                 | Most recent:       |                      |
|                                                  |                                                                                                                                                                                                                                                                                              | Tetanus/Diphtheria/ Polio (TdP)         | Most recent:       |                      |
|                                                  |                                                                                                                                                                                                                                                                                              | Tetanus/Diphtheria/ Pertussis (Tdap)    | Most recent:       |                      |
|                                                  |                                                                                                                                                                                                                                                                                              | Type:                                   |                    |                      |
| Meningitis                                       | Vaccine may be recommended if working in Microbiology Laboratory                                                                                                                                                                                                                             | Type:                                   |                    |                      |
| Seasonal Influenza                               | Recommend October 1 – March 31. See Staff/Physician Influenza Vaccination Policy                                                                                                                                                                                                             | Type:                                   | Most recent:       |                      |



CITY-WIDE HEALTH SCREEN FORM FOR ALL PROFESSIONAL STAFF/RESIDENTS/CLINICAL FELLOWS

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>2 Step TB Skin Test History</b><br>Date #1: _____<br><input type="checkbox"/> Negative <input type="checkbox"/> Positive<br><br>Date #2: _____<br><input type="checkbox"/> Negative <input type="checkbox"/> Positive | <b>If TB Skin Test <u>positive</u> in the past:</b><br><b>LHSC staff to also complete Survey for Staff With Positive TB Skin Test (see link)</b><br><a href="https://www.sjhc.london.on.ca/medical-affairs/resources/health-review">https://www.sjhc.london.on.ca/medical-affairs/resources/health-review</a><br><hr/> Date of Test: _____<br><hr/> Induration (mm): _____ <b>Endemic Travel Hx</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br><hr/> Positive results have been previously investigated?<br>(If yes attach consult note) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No<br><hr/> <b>Date of X-ray (Must be taken after the positive TB skin test; attach proof):</b> _____<br><hr/> Treatment for TB infection? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No<br><hr/> Date of Treatment: _____ |
| <b>Most recent TB Skin Test</b><br>Date: _____<br><input type="checkbox"/> Negative <input type="checkbox"/> Positive                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

Please list any medical conditions or restrictions that you may wish the Occupational Health Nurse to be aware of:

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

☐ Yes   ☐ No  
If Yes, attach proof.

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: \_\_\_\_\_

**Prior to your anticipated start date, return this completed form with proof of immunizations/testing to Occupational Health and Safety Services (OHSS) of your PRIMARY affiliation. You will be contacted if additional information or if testing is required.** If you require assistance in arranging for tests and/or vaccines, please contact OHSS who will arrange an appointment for you at one of London hospital's OHSS departments.

**Residents, Clinical Fellows and Professional Staff  
with Primary Affiliation at LHSC**

**Clinical Fellows & Professional Staff with  
Primary Affiliation at St. Joseph's**

|                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| London Health Sciences Centre<br>Victoria Hospital<br>Occupational Health and Safety Services, Rm E1-402<br>800 Commissioners Road East, London, ON N6A 5W9<br>519-685-8500 ext. 76608<br><b>Fax: 519-667-6753</b><br><b>Email: <a href="mailto:OHSS-medicalaffairs@lhsc.on.ca">OHSS-medicalaffairs@lhsc.on.ca</a></b> | St. Joseph's Health Care London<br>Occupational Health and Safety Services<br>P.O. Box 5777, Stn B<br>London, ON N6A 4V2<br>519-646-6100, ext. 64332<br><b>Fax: 519-646-6235</b> |
| <b>For Occupational Health Use Only</b><br><br>Reviewed by: _____ (OHN)      Date: _____<br><br>Notification to Medical Affairs: <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                              |                                                                                                                                                                                  |