PLEASE COMPLETE HIGHLIGHTED SECTIONS ONLY

# New Hire Pre-Placement Consent and Screening Verification

|  |  |
| --- | --- |
| Last Name: | First Name: |
| Facility: | Orientation Date: |

Welcome to the WellStar Employee Health Pre-Placement Assessment. Your health assessment today will take approximately 2 to 2.5 hours to complete. You will be seen by an Employee Health Nurse who will review your baseline health assessment and give you further instructions on how to complete the Employee Health requirements.

I give my permission to WellStar Employee Health to perform my Pre-Placement Health Assessment as a part of my requirements for employment at WellStar Health Systems. I understand that my job office is contingent upon the completion of all Employee Health requirements and medical clearance by Employee Health.

*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |
| --- | --- |
|  | Staff Initials |
| * Triage
1. Respiratory Questionnaire/ Height, Weight, B/P/Assessment
 |  |
| * Fit Testing
 |  |
| * Lab:
1. Titers
2. T Spot
 |  |
| * Human Resources
 |  |

EMPLOYEE HEALTH USE ONLY

Comments

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Baseline Health History** |
| Name: | Employee ID#: |
| Facility Name: | Department: | Date: |

|  |  |  |  |
| --- | --- | --- | --- |
| **HAVE YOU HAD ANY OF THE FOLLOWING:****YES****NO****IF YES, PLEAS E EXPLAIN** | **Yes** | **No** | **IF YES PLEASE EXPLAIN** |
| Previous positive TB skin test |  |  |  |
| Cough for more than 2 weeks |  |  |  |
| Unexplained weight loss |  |  |  |
| Unexplained fever |  |  |  |
| Loss of appetite |  |  |  |
| History of BCG vaccine |  |  |  |
| History of taking medication for TB |  |  |  |
| Previous exposure to active TB |  |  |  |
| Family member with TB  |  |  |  |
| Illness within the last two weeks |  |  |  |
| **HEALTH HISTORY** | **Yes** | **No** | **IF YES PLEASE EXPLAIN** |
| Are you under the care of a physician for High Blood Pressure? |  |  |  |
| Do you currently have or have a history of Hepatitis A, B, or C? |  |  |  |
| Do you have any diseases of the immune system?  |  |  |  |
| Do you currently take any medication that might affect your immune system? |  |  |  |
| Do you have a history of or currently have any injuries or disorders of the muscles, nerves, tendons, joints, cartilage, or spine? |  |  |  |
| Are you able to perform the essential functions of your job without modifications or accommodations? If No, please explain. |  |  |  |
| Have you traveled outside of the US in the last 6 months? If Yes, where? |  |  |  |
| **PREVIOUS WORK HISTORY** | **Yes** | **No** | **IF YES PLEASE EXPLAIN** |
| Required to wear personal protective equipment, such as:gloves, goggles, face shields, safety glasses, mask, respirator or air-supplied respirator (Indicate type used). |  |  |  |
| Have you been fit tested to wear a N95 mask? |  |  |  |
| If yes, did you have difficulty wearing the mask? Explain |  |  |  |
| **WELLNESS AND PREVENTION** | **Yes** | **No** |  |
| Do you currently use tobacco products? |  |  |  |
| Are you interested in participating in the Smoking Cessation Program that WellStar provides? |  |  |  |
| Are you interested in participating in the Wellness Program? |  |  |  |
| **CURRENT MEDICATION LIST (PRESCRIPTIONS, OVER-THE-COUNTER, VITAMINS, HERBS)** |
| Name:  | Dosage: | Name: | Dosage: |
| Name: | Dosage: | Name: | Dosage: |
| Name: | Dosage: | Name: | Dosage: |
| **ALLERGIES (INCLUDE MEDICATIONS, ENVIRONMENTAL, FOOD ALLERGIES)** |
|  |
| Do you have a latex allergy or sensitivity? YES \_\_\_\_\_, NO\_\_\_\_\_\_\_ (If yes, complete Latex Questionnaire) |
| **LIST PREVIOUS SURGERIES OR HOSPITALIZATIONS** |
|  | Date: |  | Date: |
|  | Date: |  | Date: |
| **To the best of my knowledge, the information provided by me on this form, and during the physical assessment is correct. I understand that intentional falsification may be considered cause for suspension or dismissal.*****Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| **NOTES:*****Signature of reviewing Clinician:*** |

**Pre-Placement Nurse’s Job Aid**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date |  | Name |  | Emp. # |  |
| Address |  |  |  | DOB |  |
|  | Street Address, City, State, Zip |  |  |  |  |
| Soc Sec# |  | Phone |  | Facility |  |

-------------------------------------------------------------------------------EMPLOYEE HEALTH TO COMPLETE BELOW THIS LINE-----------------------------------------------------------------------

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NH Requirements** | **Date Provided/****Completed** | **In Agility** | **Ordered** | **Results** | **Notes** |
| MMR # 1 |  |  |  |  |  |
| MMR # 2 |  |  |  |  |  |
| Mumps Titer |  |  |  |  |  |
| Rubella Titer |  |  |  |  |  |
| Rubeola Titer |  |  |  |  |  |
| Varicella # 1 |  |  |  |  |  |
| Varicella # 2 |  |  |  |  |  |
| Varicella Titer |  |  |  |  |  |
| Hepatitis B # 1 |  |  |  |  |  |
| Hepatitis B # 2 |  |  |  |  |  |
| Hepatitis B # 3 |  |  |  |  |  |
| Hepatitis BSab Quant |  |  |  |  |  |
| Td/Tdap Vaccine |  |  |  |  |  |
| Influenza Vaccine |  |  |  |  |  |
| TST | 1-2- |  |  |  |
| IGRA Tspot/QuantiFERON |  |  |  |  |  |
| Chest X-ray |  |  |  |  |  |
| Color Vision |  |  |  |  |  |
| Musculoskeletal |  |  |  |  |  |
| Latex Questionnaire |  |  |  |  |  |
| Medical Hold |  |  |  |  |  |
| Chain of Custody | Date | ID # |

Clinician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reporting Communicable Disease**

To: WellStar Health System Employees

From: Infection Control and Employee Health

RE: Reporting Communicable Disease

It is required by law that all Georgia Physician, Laboratories, and other Health Care Providers report any Communicable Disease to their County Health Department of District Health Office.

WellStar Communicable Disease Policy requires that all communicable disease be reported to Employee Health at the time you are exposed and/or become symptomatic. If work restrictions are indicated, employees are required to be cleared by

Employee Health before returning to work.

Examples to Reportable Communicable Disease are as follows:

* Hepatitis A, B or C
* Chickenpox
* Measles, Mumps or Rubella
* Influenza
* SARS
* Neisseria Meningitis
* Scabies/Lice
* Conjunctivitis
* Active TB
* Bordetella Pertussis

Please refer to the Infection Prevention web page located on eSource, Sections: Communicable Diseases.

You may also contact WellStar Employee Health Office @770-793-7222 for any questions.

Thank you,

Employee Health Services

Infection Prevention Department