Occupational Health Service

NON-EMPLOYEE PRE-PLACEMENT HEALTH EXAMINATION
BY PRIVATE PHYSICIAN

Name_____
Last First

Date of Birth_____ Title_____ Dept._____ Work Location_____

1. **TO PHYSICIAN: A pre-placement health examination is required for the above-named person. Please enter details of all requested information. LABORATORY REPORTS MUST BE ATTACHED. *Incomplete or illegible information may be rejected*. Thank you.**

2. **Medical History:**
   - Any major illness or health impairment_____
   - Hospitalization/Serious injury_____
   - Allergy_____
   - Medication currently being taken:_____

3. **Physical Examination** (notate all spaces; draw-through lines not acceptable):

   T_____ P_____ R_____ BP_____ Hgt_____ Wgt_____

   Gen_____ HEENT_____ Neck_____

   Lungs_____ Heart_____ Abd_____ Ext_____

   Musculoskeletal_____ Neuro_____

4. **Two (2) PPD Tests (Mantoux) or one (1) Interferon Gamma Release Assay (e.g. Quantiferon) required:**

   PPD Test 1 Date injected:_____ (mm/dd/yy) Date read:_____ (mm/dd/yy) (within last 12 months) Induration:_____ (mm)

   PPD Test 2 Date injected:_____ (mm/dd/yy) Date read:_____ (mm/dd/yy) (within last 3 months) Induration:_____ (mm)

   If PPD positive, what was the earliest date of positive PPD?_____ History of BCG? YES____ NO____ Date_____

   Was Tb prophylaxis taken? NO ____ YES _____ What medication?_____ How long?_____

   In your opinion what caused positive PPD?_____

   Quantiferon (or other IGRA within last 3 months): Date**:**_____ (mm/dd/yy) Result**:**_____

5. **Chest X-Ray** (for positive PPD or positive IGRA) **Chest x-ray** report must be attached.

6. **Rubella** antibody titer:_____ **Laboratory report must be attached** OR vaccine date:_____ (mm/dd/yy)

7. **Rubeola** antibody titer:_____ **Laboratory report must be attached**. OR

   2 doses of live vaccine dates: (1)_____ (mm/dd/yy) (2)_____ (mm/dd/yy)

8. **Mumps** antibody titer:_____ **Laboratory report must be attached**. OR

   2 doses of live vaccine dates: (1)_____ (mm/dd/yy) (2)_____ (mm/dd/yy)

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9. Varicella antibody titer: (required in all cases) _____ **Laboratory report must be attached**.

Vaccination (optional) dates: (1)_____ (2)_____
(mm/dd/yy) (mm/dd/yy)

10. Hepatitis B surface antibody titer:_____ **Laboratory report must be attached**.

vaccine dates: (1)_____ (2)_____ (3)_____ (mm/dd/yy)

or

Hepatitis B Vaccine declination signed with clinical witness signature.

11. Td/Tdap vaccine (within 10 years) date:_____ (mm/dd/yy)

12. Urine Toxicology

- Must be performed by Quest Diagnostics: Test 3519N SAP 10-50/2000 W/NIT.
- Must be no more than six (6) weeks prior to review by Bellevue Occupational Health Service.
- Must attach legible copy of original Quest report.
- Must attach legible copy of Quest Custody and Control form.
- Volunteers and students shall be processed for toxicology test at Bellevue OHS.

13. Respirator Fit-Test (using Kimberly-Clark N95 Particulate Filter Respirator). *The Respirator Fit-test is required for **all clinical staff**. It is also required for **all other staff** whose work requires entry into a room or area with patient under **Tb Isolation or Airborne Isolation**. Medical evaluation for respirator use must be performed before respirator fit-test.*

14. If respirator fit-test not required, then **Bellevue Respirator Preliminary Questionnaire** form completed with supervisor's signature must be provided.

_____ _____

Physician Signature **Date**

Physician Name printed or stamp:_____

License number:_____ State:_____

Address:_____

_____

_____

Telephone: _____