Preplacement Screening Patient Contact Form

The information requested on these pages is necessary in order to minimize any occupational risks to you and to insure that you can safely perform the essential functions of your new job. Medical History information on this form will be kept in a confidential file at the SHCC, and will not be shared with your Employer, Program or Director without your written permission/consent. Immunization Documentation may be shared with your Program and the Occupational Medicine Department of your work site.

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm / dd / yy)

SS#: _____ **UF ID#:** _____

Work Site - Gainesville: _____ **Jacksonville:** _____ **Other:** _____

Position Number: _____ **Job Title:** _____

Department: _____ **Supervisor/Prog Director:** _____

Section I - Medical History

Do you have now, have you ever had, or have you received treatment for the following:

Yes	No		If ***YES*** use as many lines below as needed to explain
☐	☐	Hospitalizations/Surgeries	
☐	☐	Allergies to medications/foods	
☐	☐	Current Medications: doses and Frequency	
☐	☐	Visual loss (one or both eyes)	
☐	☐	Blindness	
☐	☐	Tuberculosis	
☐	☐	Difficulty hearing/hearing aides	
☐	☐	Deafness	
☐	☐	HIV	
☐	☐	Allergic rhinitis	
☐	☐	Hepatitis (type)	
☐	☐	Other liver disease (type)	
☐	☐	Diabetes (type)	
☐	☐	Carpal tunnel syndrome	
☐	☐	Other hand/wrist problems	
☐	☐	Back or neck injury	
☐	☐	Chronic back pain	

Preplacement Screening Patient Contact Form

Name: _____ **UFID#:** _____

Yes	No		If ***YES*** use as many lines below as needed to explain
☐	☐	Disc problems or sciatica	
☐	☐	Limited activities due to back or neck injury or pain	
☐	☐	Seizures	
☐	☐	Alcohol abuse/alcoholism	
☐	☐	Drug abuse/addiction	
☐	☐	Immunosuppression	
☐	☐	Latex allergy or other skin sensitivities	

Have you ever had a work-related illness or injury? Yes ___ No

If yes, explain: _____

Are you currently recovering from any significant illness or injury? Yes ___ No

If yes, explain: _____

Do you have any medical or psychological conditions that you feel may prevent you from completely and safely performing the duties outlined in your job description, or do you require/request any modifications to your job duties? Yes ___ No ___ If yes, explain: _____

_____

In working with patients you will have the potential for mutual exposures to blood borne pathogens and communicable diseases. You have an ethical and legal obligation to ***disclose any chronic communicable disease or blood borne pathogen infection****, such as HIV, Hepatitis C, or Hepatitis B, prior to placement. Failure to do so may be grounds for dismissal.*

Do you have a communicable disease or blood borne pathogen infection?

_____

Would you like to speak to a UF Student Health / Occupational Medicine clinician about any of the information you have given above? Yes ___ No ___ If yes, daytime phone (_____) _____

How may we contact you if we need more information?

E-mail address: _____ **Phone#:** _____

Mailing Address: _____

Other #s: _____

Signature: _____ Date: _____

UF UNIVERSITY of FLORIDA Preplacement Screening Patient Contact Form

Name: Date of Birth: UF ID #:

Required Immunizations

Positive titer for immunity will substitue for shots on numbers 1 - 5. Titers must have labs attached.*

	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Titer Date & Result*
1. **Measles** (2 doses after 1st birthday)			\\\\\\\\\\	
2. **Mumps** (2 doses after 1st birthday)			\\\\\\\\\\	
3. **Rubella** (2 doses after 1st birthday)			\\\\\\\\\\	
4. **Varicella** (Chicken Pox; 2 doses)			\\\\\\\\\\	
5. **Hepatitis B** (3 doses or positive titer)				
6. **Tdap** (adult booster from 2005 or later)		\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		

Required Tuberculosis Screening

Tuberculosis screening must be either: 2 negative TST's** (PPD's) or a negative Interferon Assay within 12 months prior to start date. BCG is not a substitute for a previous positive screening for TB. If there is a history of a prior positive TB screening result then see below.

PPD** #1 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
PPD** #2 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (instead of PPD's)		Date	Result	

(OR)

If past positive PPD or positive Interferon Assay you must submit documentation: 1) the positive screening BCG is not a substitute for a previous positive screening for TB, 2) chest x-ray within 12 months prior to start date (record below), and 3) UF TB surveillance form.

Past positive PPD Skin Test	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (attach copy of lab)		Date	Result	
CXR* (only if past positive PPD)		Date	Result	

*All titers, assays, and chest X-rays must have results attached

**TST's(PPD's) placements should be at least 7 days apart and cannot be placed within 28 after a live virus immunization like measles, mumps, rubella, or varicella. TST's(PPD's) should be read within 48 - 72 after placement.

Official Office Stamp Here **Authorized Signature** **Date**

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must appear here or this form will not be approved. You may not be the authorized signator of your own form.

Phone: (352) 294-5700 | Fax: (352) 846-2003
University of Florida - Student Health Care Center
Occupational Medicine: SHCC@Shands
P.O. Box 100148, Gainesville, FL 32610-0148

WMC-002: Reviewed/revised 2013-01