FAIRVIEW

Practitioners are responsible for obtaining satisfactory documentation and any associated costs to meet Fairview Health Services requirements.

Screening & Immunizations/Immunity	REQUIRED DOCUMENTATION Return Required Documentation To: DEPT-EOHS-CREDENTIALING@fairview.org
Tuberculosis Symptom Survey Screen AND Tuberculin Test	**Acceptable historical record of tuberculosis screening includes:** (see attached form) • Completion of the attached TB surveillance questionnaire with your signature and date (required). *NOTE: The TB skin test section of the form can be used for skin test documentation purposes or you may submit documentation from the clinic where the TB skin test or the blood assay for mycobacterium tuberculosis with results and reference range, were performed.* **AND** • Negative 2-step Mantoux skin test (***completed up to 90 days prior*** to Fairview start date) **OR** • Blood assay results for Mycobacterium Tuberculosis(BAMT) test (QGold) (***completed up to 90 days prior*** to Fairview start date) • **OR** • Documentation of previous **positive** PPD or BAMT **AND** documentation of completed INH medication therapy **AND** documentation of chest x-ray ***within 1 year prior*** to Fairview start date ***and 12 months after conversion*** (if conversion was >12 months)
Measles, Mumps and Rubella (MMR) & Varicella	**Acceptable historical record of measles, mumps, rubella and varicella immunity or vaccination includes:** Two **(2)** live virus vaccines for: • Measles, Mumps, Rubella (MMR) ***AND*** Varicella **OR** • Documentation of positive titer *(Record of all four (4) vaccines or immunity results with lab values are required)*
Hepatitis B	**Acceptable historical record of Hepatitis B vaccination or immunity includes:** • Medical documentation of completed Hepatitis B vaccination series (including dates) **OR** • Medical documentation of positive Hepatitis B immunity titer **OR** • Signed and dated declination form **Note: If you wish to decline the vaccination, sign and return the attached declination form to DEPT-EOHS-CREDENTIALING@Fairview.org**
Immunizations	**REQUESTED DOCUMENTATION *(not required)*** **Return Requested Documentation To: DEPT-EOHS-CREDENTIALING@Fairview.org**
Tdap	**Acceptable historical record of Tdap vaccination:** • Documentation of most recent adult Tdap vaccination

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Tuberculosis Screening

Last name, First name, Middle initial	Date	( ) Work, Home or Cell Phone Number
Date of Birth	Fairview ID Number	SSN if not current Fairview Employee

YES	NO	DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? * +
		Chest pain
		Coughing for more than 3 weeks
		Coughing up blood
		Unexplained fatigue (extremely tired without a reason)
		Unexplained fever/chills
		Unexplained night sweats
		Unexplained weight loss, poor appetite
		Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a tumor necrosis factor (TNF) alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication+

YES	NO	HAVE YOU * +
		Ever had the BCG (bacille Calmette-Guerin) vaccine (a vaccine for tuberculosis (TB) disease used in many countries with a high prevalence of TB)
		Ever been treated for latent TB infection (IF YES, DATES TREATED)_____
		Ever been treated for active TB disease (IF YES, DATES TREATED)_____
		Ever had an adverse reaction to a TB skin test (EXPLAIN)_____
		Received a live-virus vaccine within the past 6 weeks
		Ever had a positive reaction to a TB skin test or TB blood test: If YES, Date _____Number of MM induration_____
		Had a TB skin test in the past 12 months: If YES, Date _____Number of MM induration_____ Result_____
		Had close contact with someone who has had infectious TB disease since your last TB test +

YES	NO	HAVE YOU EVER BEEN OR ARE YOU +
		A temporary or permanent resident (for ≥1 month) in a country with a high TB rate (i.e., *any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)*

Date	Legible Printed Name of Worker completing questions If TST administered, name of worker consenting to TST	Legible Signature of Worker completing questions If TST administered, name of worker consenting to TST
Date	Printed Name of OHN reviewing symptom survey	Signature of OHN reviewing symptom survey

TUBERCULIN SKIN TEST (TST)	TST – First Step	TST – Second Step
Administration		
Name of person administering test		
Date and time administered		
Location (circle)	◯L forearm ◯R forearm Other:_____	◯L forearm ◯R forearm Other:_____
Tuberculin manufacturer		
Tuberculin expiration date and lot #		
Signature of person who administered test		
Results (read between 48-72 hours)		
Date and time read:		
Number of mm of induration: (**across** forearm)	____mm	____mm
Interpretation of reading (circle)	☐Positive* ☐Negative***	☐Positive** ☐Negative
Reader's signature		

* Refer "YES" responses to EOHS before TST is administered

** If result is positive, refer to Tuberculosis Medical Surveillance Policy/Procedure for next steps

*** If result is negative, perform second step TST in one to three weeks *(as applicable)*

\+ Health care personnel should be considered at increased risk for TB if they answer "yes" to any of the + statements

Adapted from MN DOH TB Screening Tools and MMWR / May 17, 2019 / Vol. 68 / No. 19

Hepatitis B Questionnaire/Declination for Credentialed Practitioners

Return to: DEPT-EOHS-CREDENTIALING@Fairview.org

Name _____ **Last four SS#** _____

Date of birth _____ **Job Title** _____

☐ 1) I have received Hepatitis B vaccine in the past.

☐**series of three completed:** MUST attach medical documentation to support (including dates vaccine was received)

☐**series incomplete, number of shots given _____ and year given _____**

Hepatitis B titer results

☐unknown / not previously drawn

☐not immune

☐known immune (MUST attach medical documentation to support)

☐ 2) I have not received Hepatitis B vaccine in the past and I would like to receive the Hepatitis B vaccination

☐I would like to receive the Hepatitis B vaccine. I will contact Employee Occupational Health Services at 612-672-5050 to schedule the vaccination series. I understand that the vaccination series will be 3 doses and that it is my responsibility to complete the entire series, or contact Employee Occupational Health Services to sign a declination. Failure to respond to an EOHS reminder letter within 2 weeks of letter date will serve as my declination.

☐ 3) DECLINATION **(OSHA 1910.1030, App A)**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis vaccine, at no charge to Fairview employees. However, I decline Hepatitis B vaccination at this time. I understand by declining this vaccine I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B vaccine, I can complete the vaccination series at no charge to Fairview employees.

I do not wish to receive the Hepatitis B vaccine at this time. (Please sign declination below)

Signature (for declination only) _____ **Date** _____

A collaboration among the University of Minnesota,
University of Minnesota Physicians and Fairview Health Services

Tuberculosis (TB) Signs and Symptoms Questionnaire

Last name, First name, Middle initial	Date	( ) Work, Home or Cell Phone Number
Date of Birth	Fairview ID Number	SSN if not current Fairview Employee

TB Symptom Review		
YES	**NO**	**DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?*+**
☐	☐	Unintended weight loss >10 pounds
☐	☐	Loss of appetite
☐	☐	Drenching night sweats
☐	☐	Unexplained fever for more than 3 weeks
☐	☐	Unexplained fatigue for more than 3 weeks
☐	☐	Chills
☐	☐	Cough for more than 3 weeks with sputum production
☐	☐	Bloody sputum
☐	☐	Coughing up blood
☐	☐	Chest pain
Individual History		
YES	**NO**	**HAVE YOU**
☐	☐	Had a TB skin test in the past 12 months? Date: Result:
☐	☐	Ever had the BCG (bacille Calmette-Guerin) vaccine (a vaccine for tuberculosis (TB) disease used in many countries with a high prevalence of TB)?*+
☐	☐	Had a live-virus vaccination within the past 6 weeks?*
☐	☐	Had a COVID-19 vaccination within the past 4 weeks?*++
TB History		
YES	**NO**	**HAVE YOU***
☐	☐	Ever had a necrotic, blistering, ulcerated, anaphylactic or other adverse or allergic reaction to a TB skin test?* If yes, please describe:
☐	☐	Ever has a positive result to a TB skin test (e.g. TST, Mantoux)?+ Date: Number of mm Induration:
☐	☐	Ever has a positive result to a TB blood test (e.g. IGRA, BAMT, QFT, TSpot)?+ Date:
☐	☐	Ever been diagnosed with latent TB infection (LTBI)?+ Date:
☐	☐	Ever been diagnosed with active TB disease?+ Date:
☐	☐	Ever been treated for LTBI or active TB disease?+ If yes, please answer the following: What year did you take the medication? Name and location of treating doctor or clinic: Name of medication: Number of months taking medication: Did you finish taking all the medication as prescribed? Yes or No
Risk Factors for TB Exposure		
YES	**NO**	**HAVE YOU**
☐	☐	Had close contact or a known exposure to someone with active TB disease since your last TB skin or blood test?*+
☐	☐	Ever spent more than 30 days in a country with an elevated TB rate?+(This includes all countries except those in Western Europe, Northern Europe, Canada, Australia, New Zealand and the US.)
Risk Factors for LTBI Progression to active TB disease		
YES	**NO**	**DO YOU**
☐	☐	Have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator?+

Date	**Legible Printed Name of Worker completing questions If TST administered, name of worker consenting to TST**	**Legible Signature of Worker completing questions If TST administered, name of worker consenting to TST**
Date	**Legible Printed Name of OHN reviewing symptom survey**	**Signature of OHN reviewing symptom survey**

A collaboration among the University of Minnesota,
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Tuberculosis Skin Test

TUBERCULIN SKIN TEST (TST)	**TST – First Step (Required for Annual)**	**TST – Second Step (Optional/Situational for Annual)**
Administration		
Name of person administering test		
Date and time administered		
Location (circle)	◯L forearm◯R forearm Other:_____	◯L forearm◯R forearm Other:_____
Tuberculin manufacturer		
Tuberculin expiration date and lot #		
Signature of person who administered TST		
Legible Printed Name of OHN who administered TST		
Results (read between 48-72 hours)		
Date and time read:		
Number of mm of induration: (**across** forearm)	____mm	____mm
Interpretation of reading (circle)	Positive☐ Negative☐*	Positive☐ Negative☐
Reader's signature		
Legible Printed Name of OHN or designee who read TST		

* Refer "YES" responses to EOHS before TST is administered.

** If result is positive, refer to Tuberculosis Medical Surveillance Policy/Procedure for next steps.

*** If result is negative, perform second step TST in one to three weeks *(as applicable).*

\+ Health care personnel should be considered at increased risk for TB if they answer "yes" to any of the + statements

++Please refer to Interim clinical considerations for use of covid-19 vaccines. (2021, March 05). Retrieved March 11, 2021, from https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html

This document is adapted from MN DOH TB Screening Tools, MMWR / May 17, 2019 / Vol. 68 / No. 19, and Appendix 3 from 2020 ACOEM Guidance Statement: Tuberculosis screening, testing, and treatment of us health care personnel.