INSTRUCTIONS FOR COMPLETING THE IMMUNISATION QUESTIONNAIRE & CONSENT FORM

1. Complete **all** the details required including the cost centre and fund number.

2. Ask the department contact (i.e. Resources Manager/Supervisor) to complete their details and sign where indicated (Part 1).

3. Ensure the form has been signed and dated by you (Part 3).

4. Send via email from your staff/student email address to the Occupational Health Nurse Consultants at: BPD-OHNC@monash.edu

When the form is received at Occupational Health and Safety you will be notified (by email) with details of how to arrange the necessary immunisation.

Please call one of the Occupational Health Nurse Consultants at Occupational Health and Safety on 9905 1014 if you have any queries.

MONASH University

TUBERCULOSIS SCREENING

QUESTIONNAIRE & CONSENT FORM

Sections 1-3 must be completed by the person requiring the immunisation prior to authorisation by OHS.

Part 1 - Pre-Screening Details

Surname Given names .

Date of Birth M ❑ F ❑ I.D. Number Tel

Department ……..Campus ……

Building …… Room number……Cost Centre …… Fund No……..

Dept contact name……Dept contact signature ……..... Dept contact telephone……..

Part 2 - Reason for Screening and Medical History

Reason for screening: (please tick ✓) ❑ Clinical work ❑ Laboratory work ❑ Working with animals ❑ 5 yearly health surveillance

Please answer "yes" or "no" to the following questions:			YES	NO
1. Have you ever had	-	tuberculosis	❑	❑
	-	serious chest infections	❑	❑
	-	exposure to anyone known or suspected to have tuberculosis	❑	❑
	-	worked or lived overseas for more than 3months in an area with high incidence of TB disease?	❑	❑
2. Have you previously had a Mantoux or Quantiferon TB Gold blood test			❑	❑
If yes, please give approximate date/s and the result if known				
3. Have you ever had a BCG? If yes, when?			❑	❑
4. Do you currently have	-	any allergies (please list and include reaction)	❑	❑

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	-	immune system deficiency	❑	❑
	-	any illness	❑	❑
5. Are you taking any medication (e.g. tablets, capsules, puffers, creams)?			❑	❑

If yes, please list

……

6. Are you pregnant, trying to become pregnant or breast feeding?	❑	❑
7. Do you have any concerns about your health?	❑	❑

If yes, please list

……

…

Part 3 - Declaration

1. I understand that a blood test (Quantiferon Tb Gold) will be performed to check whether or not I have had exposure to tuberculosis.
2. I understand that Part 4 of this form will be completed by the clinic which performs the screening. On completion of the TB screening program, this form will be forwarded by the immunising clinic to OHS.
3. I understand that my Manager/Supervisor may be notified regarding my immunisation status and if asked I can provide verification.
4. I consent to Quantiferon Tb Gold testing and to follow up if required.

Signed: ..... Date: ...../...../.....

Part 4 - Immunisation Record – Quantiferon TB Gold test (To be completed by Doctor/Nurse)

Date of Quantiferon Tb Gold test :...../...../.....

Result: Interpretation:

Repeat Quantiferon Tb Gold test required (if indeterminate) Yes ❑ No ❑

Date of Quantiferon Tb Gold test :...../...../.....

Result: Interpretation:

Chest Xray & Referral to Infectious Disease Specialist required Yes ❑ No ❑

Surveillance program required Yes ❑ No ❑

Part 5 - Privacy Statement

The information on this form is collected for the primary purpose of providing high quality health care. It may also be used for a related secondary purpose that complies with legislative reporting requirements. The information collected on this form may be disclosed to others involved in your health care and government departments such as the Department of Human Services as required under mandatory reporting requirements. If all of the information requested is not provided, it may compromise the quality of the health care and treatment given to you, and may not be possible for the university to meet its legal obligations. You have a right to access personal information that Monash University holds about you, subject to any exceptions in relevant legislation. To do this, please contact the Monash University Privacy Officer at privacyofficer@monash.edu

Surveillance Program

Date of Quantiferon Test: / /

Result: Interpretation:

Date of Chest Xray……/……/…….. Result……

Date of Sputum test ……../……../…… Result……

Details of Infectious Disease Specialist ……

Date of commencement of treatment ……/……../……

Date of completion of treatment ……/……../……

Date of sputum test (3 months after completion of treatment ……../……/……. Result ……..

Retesting required for Quantiferon Tb Gold test Date ……/……/……

Reason ……..

Date of Quantiferon Test: / /

Result: Interpretation:

Chest Xray & Referral to Infectious Disease Specialist required Yes ❑ No ❑

Retesting required for Quantiferon Tb Gold test Date ……/……/……

Reason ……..

Date of Quantiferon Test: / /

Result: Interpretation:

Chest Xray & Referral to Infectious Disease Specialist required Yes ❑ No ❑

Retesting required for Quantiferon Tb Gold test Date ……/……/……

Reason ……..

Date of Quantiferon Test: / /

Result: Interpretation:

Chest Xray & Referral to Infectious Disease Specialist required Yes ❑ No ❑