PRE-EMPLOYMENT IMMUNISATION AND SCREENING FORM

It is a requirement of your employment that you complete the pre-employment immunisation screening form.

This ensures that compliance with current Infection Prevention and Control and Occupational Safety and Health protocols are met.

Each health worker has a responsibility to ensure that his/her immunisation status in relation to Vaccine Preventable Diseases (VPD) is current and appropriate.

This form will:

- Assess new Staff Members immunisation status for Vaccine Preventable Diseases.
- Determine if screening for multi-resistant organisms is required.

Please complete the relevant sections of this form according to your position/work area and **return it to the hospice prior to your commencement date**. Evidence of immunity/vaccination **MUST be** attached and returned with this form as determined by employee category below.

The information is then placed on the hospice's Immunisation Database. All information on the database remains confidential and privacy policies are strictly adhered to. The database is used to determine your VPD status in the event of exposure to a VPD during your employment.

STAFF MEMBER DETAILS	
Surname	
Given Name(s)	
Address	
Contact Telephone	
Date of Birth	
Anticipated Start Date	

Area of Work	Exposure Risk	Employee Category	Section/Evidence
Nursing **Housekeeping** **Patient Care** **Medical**	**Direct contact with blood or body substances.** Includes all HCW who have physical contact with or potential for exposure to blood or body substances.	**A**	**Complete SECTION 1-5** Must attach evidence of vaccination or immunity.
Catering **Support Services**	**Indirect contact with blood and body substances** Rarely have direct contact with blood or body substances. Potential for contact with infectious diseases.	**B**	**Complete SECTION 1-2, 4 & 5 ONLY.** Must attach evidence of MRSA screening (if applicable) COVID-19 vaccination and tuberculosis screening.
Administration **Maintenance** **Reception**	**Minimal patient contact** No greater risk of exposure to infectious diseases than the general public.	**C**	**Complete SECTION 1 & 5 ONLY.** Must attach evidence of MRSA screening (if applicable) and COVID-19 vaccination.

Please answer the following questions by ticking the boxes which apply to you.
Please attach evidence of vaccination or serology confirmation of immunity to this form as stated on page 1.

SECTION 1

METHICILLIN RESISTANT STAPHLOCOCCUS AUREUS (MRSA)		
Part one (All staff to complete)	**Yes**	**No**
Have you worked in, or been a patient in a hospital or Residential Care Facility **outside of WA** in the last 12 months?	☐	☐
Part Two – To be completed if you answered **Yes** to **Part One**		
Have you been screened for MRSA in WA in the last 12 months (if **Yes**, attach evidence)	☐	☐
If you answered **No,** you require screening for MRSA before commencing work. Please contact your GP to arrange screening swabs. **You cannot commence employment until screening results are known.** **Date taken: _____ Result: _____**		

COVID-19	Yes	No
Have you been immunised against COVID-19?	☐	☐
If no, do you have a medical exemption?	☐	☐
*If **Yes,** state date and number of vaccines received (2 doses required for full immunity)* ☐ 1st Dose received - Date: _____ ☐ 2nd Dose received - Date: _____		

SKIN CONDITIONS	Yes	No
Do you have damaged or weeping skin or chronic exfoliate skin conditions such as eczema, psoriasis or dermatitis? (psoriasis can be in the hair).	☐	☐
Do you have a known latex allergy?	☐	☐
*If **yes** to either of the questions above please give details of severity and treatment*		

VACCINES	Yes	No
Do you have any known allergies and/or contradictions to vaccines?	☐	☐
*If **yes** to the question above please provide details*		

MEASLES / MUMPS / RUBELLA (MMR)	Yes	No	Uncertain
Have you been immunised against MMR?	☐	☐	☐
*If **Yes,** state date and number of vaccines received (2 doses required for full immunity)* ☐ 1st Dose received - Date: _____ ☐ 2nd Dose received - Date: _____			
Did you have a blood test to confirm immunity?	☐	☐	
If **YES,** were you immune?	☐	☐	

CATEGORY C WORKERS, ANSWER NO MORE QUESTIONS & PROCEED TO SECTION 5

SECTION 2			
Diphtheria/tetanus/PERTUSSIS (Whooping Cough) (dTPa)	**Yes**	**No**	**Uncertain**
Have you had an adult booster for Tetanus and Pertussis dTPa in the last 10 years?	☐	☐	☐
Have you had a blood test to confirm immunity?	☐	☐	☐
If **YES**, were you immune?	☐	☐	☐
VARICELLA (Chicken pox)	**Yes**	**No**	**Uncertain**
Have you had chicken pox?	☐	☐	☐
Have you been immunised against Varicella? (2 doses required for immunity)	☐	☐	☐
Have you had a blood test to confirm immunity?	☐	☐	☐
If YES, were you immune?	☐	☐	☐
CATEGORY B WORKERS, ANSWER NO MORE QUESTIONS & PROCEED TO SECTION 4			

SECTION 3			
HEPATITIS B *Strongly recommended if you are at occupational risk and likely to come into contact with blood or body fluids.*	**Yes**	**No**	**Uncertain**
Have you been vaccinated against hepatitis B? *(attach evidence)*	☐	☐	☐
Have you had a blood test to confirm immunity?	☐	☐	☐
If **YES** were you immune? (attach evidence)	☐	☐	☐
HEPATITIS A	**Yes**	**No**	**Uncertain**
Have you been vaccinated against Hepatitis A (attach evidence)	☐	☐	☐
Have you had a blood test to confirm your immunity?	☐	☐	☐

SECTION 4			
TUBERCULOSIS (BCG)			
	Yes	**No**	
Have you had BCG Vaccination?	☐	☐	
Have you had a Mantoux skin test before?	☐	☐	**Date:** **Result:**
Have you had QuantiFERON test?	☐	☐	**Date:** **Result:**
Have you ever been treated for TB in the past?	☐	☐	**Date:**
Have you had contact with somebody that suffered from TB either personally or at work?	☐	☐	**Date:**
Have you had a Chest x-ray recently for any reason.	☐	☐	**State:**
Country of Birth:	Are you Aboriginal or Torres Strait Islander? Y ☐ N ☐		
State which countries have you lived or worked in for more than 6 months, other than your country of birth:			

SECTION 5	
I declare the above information is accurate to the very best of my current knowledge and I have attached copies of my vaccination status and / or laboratory results as required. I understand that if I decline to be immunised, or cannot demonstrate immunity against vaccine-preventable diseases, that I may be excluded from any position in contact with patients or members of the public where there is a risk of my contracting the infection, or transmitting it to patients/members of the public.	
Signature:	**Date:**

OFFICE USE ONLY	
Serology Test Required?	☐ Hepatitis A ☐ Hepatitis B ☐ Varicella ☐ MMR ☐ dTPa
Vaccination Recommended?	☐ Hepatitis A ☐ Hepatitis B ☐ Varicella ☐ MMR ☐ dTPa ☐ COVID-19
Risk of TB – further assessment required?	☐ Yes ☐ No
MRSA Screening Required?	☐ Yes ☐ No