Hospital of the University of Pennsylvania
Occupational Medicine

To: All Incoming House Staff

From: Amy J. Behrman, M.D.
Medical Director
Dorothy Dragoni, RN, BSN
Surveillance and Compliance Coordinator

RE: Employment health history and medical evaluation

Date: March 15, 2009

Welcome to the University of Pennsylvania Health System.

You are required by the Medical Board to document your health history and immunization status. This requirement must be completed prior to your arrival in June. House Staff Orientation Day has an intense schedule. **Do not delay until House Staff Day to obtain copies of this information from your prior institution. If all of your records with Occupational Medicine are completed and received prior to that day, you can save yourself considerable time and effort.**

Please **review, complete, and send** the attached set of forms and obtain documentation per the attached memo.

Mail complete sets of forms and all documentation to:

Dorothy Dragoni, RN, BSN
Compliance Coordinator
Hospital of the University of Pennsylvania
Occupational Medicine
3400 Spruce Street, Ground Floor, Silverstein Building
Philadelphia, PA 19104-4283

These forms, along with copies of immunizations and TB screenings are necessary for your payroll clearance. Save copies of all of your records. You will need them in all future healthcare institutions. **These records are <u>not</u> automatically forwarded from your school, not even from the University of Pennsylvania**. You must sign for, request and receive them. When your information has been received by Occupational Medicine, an Occupational Medicine practitioner will call you and confirm that it has been received and inform you if you require anything further.

If you have any questions, please contact the Occupational Medicine Department at 215-614-0462. You may call to confirm that we received your information and that it is complete. **Do not fax these documents.**

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University of Pennsylvania Medical Center
Hospital of the University of Pennsylvania
Occupational Medicine
Medical Record Request Form

You must have a Medical Record Number in order to complete the Occupational Medicine Forms in the attached packet.

To generate your Medical Record Number you must call - (215) 615-2240

Before you can start work and receive payroll clearance it is your responsibility to make sure that all forms are completed and returned to Occupational Medicine

Listed below are the questions that you will be asked to obtain your medical record number. Please make sure that you write your medical record number on the forms.

Enter Medical Record Number: ____________________

1. Last Name: ____________________ First Name: ____________________ MI:_____
2. Social Security Number: ______________________________ (last 4 digits only)
3. Date of Birth: ______________________________
4. Marital Status: ______________________________
5. Sex: Male ________ Female ________
6. Mother's First Name: ______________________________
7. Father's First Name: ______________________________
8. Home Phone Number: ______________________________
9. Cell Phone Number: ______________________________
10. Day Phone Number: ______________________________
11. Pager Number: ______________________________
12. Home Address: ______________________________
13. Home or Work E-mail: ______________________________
14. Hospital Department: ______________________________
15. Work Phone Number: ______________________________
16. Post Graduate Year: ______________________________
17. Emergency Contact: ______________________________
18. Emergency Phone Number: ______________________________
19. Relationship of Contact: ______________________________

Please complete all of the information on the following forms.

Hospital of the University of Pennsylvania
Health History for Residents and Fellows
Occupational Medicine

Last Name: ______________________ **First Name:** ______________________ **MI** __

Medical Record Number: ______________________ **Date of Birth:** ________________

Allergies: Drug ____________________ Food ____________________ Seasonal ____________

Latex ____________________ Animals ________________ Other ______________

Present Medications: ____

(e.g. aspirin, contraceptives, vitamins, over the counter, herbal and prescribed medications)

Childhood and Adult Diseases or Immunizations (Indicate dates & whether disease or vaccine)

Chicken Pox (Varicella): ____________________ Hepatitis A: ____________________

Measles (Rubeola): ____________________ Hepatitis B: ____________________

Mumps: ____________________ Hepatitis C: ____________________

German Measles (Rubella): ____________________ Tetanus Booster: ________________

Smallpox (Vaccinia): ____________________ Influenza: ____________________

Family History (circle all appropriate)

Tuberculosis Diabetes Hypertension Heart Attack Stroke Blood Disease Kidney Disease

Mental Illness Cancer

Explain: ____

____

PAST MEDICAL HISTORY

Tuberculosis

Date of last TB test (PPD): ______________ Results: ________________

If positive, was this a conversion? Yes_______ No _______ N/A __

Date of last chest x-ray: ____________ Results: ________________

Have you had BCG? Yes _______ No _______

Have you received preventive treatment for TB? Yes _______ No _______

If yes, how long? ____________________ N/A __

Have you ever had tuberculosis (TB)? Yes _______ No _______

If yes, how long? ____________________ N/A __

If you had TB, what was your treatment? ________________________________

Are you taking any immunosuppressive medications? Yes _______ No _______

HAVE YOU HAD ANY OF THE FOLLOWING?

	Circle One	If yes, explain.
EARS, EYES, NOSE, THROAT		
Eye Problems (Blurred Vision, Infections, Double Vision)	Yes No	____________
Ear Infections	Yes No	____________
Decreased Hearing Activity	Yes No	____________
Nose / Sinus Problems	Yes No	____________
Mouth Ulcers / Lesions	Yes No	____________
Tonsillitis / Sore Throat	Yes No	____________
CARDIAC		
Heart Disease or Heart Attack	Yes No	____________
Palpitations	Yes No	____________
Angina / Chest Pain	Yes No	____________
High Blood Pressure / Low Blood Pressure	Yes No	____________
Rheumatic Fever	Yes No	____________
Murmurs / Clicks / Irregular Heart Beat	Yes No	____________
RESPIRATORY		
Asthma / Bronchitis / Pneumonia	Yes No	____________
Emphysema	Yes No	____________
Frequent or Chronic Colds	Yes No	____________
Lung Problems	Yes No	____________
Shortness of Breath	Yes No	____________
Sleep Apnea or Excessive Snoring	Yes No	____________
GASTROINTESTINAL		
Stomach Ulcer / Indigestion / Gastritis	Yes No	____________
Esophageal Reflux	Yes No	____________
Persistent Vomiting	Yes No	____________
Hemorrhoids / Rectal Fissures	Yes No	____________
Hiatal Hernia	Yes No	____________
Gallbladder Disease	Yes No	____________
Chronic Constipation / Diarrhea	Yes No	____________
Rectal Bleeding	Yes No	____________
Hepatitis or Liver Disease	Yes No	____________
Unexplained Weight Gain	Yes No	____________
Unexplained Weight Loss	Yes No	____________
Ethnic / Cultural Dietary Preferences	Yes No	____________
GENITOURINARY		
Kidney / Bladder Disorder	Yes No	____________
Painful Urination	Yes No	____________
Blood / Pus / Stone in Urine	Yes No	____________
Venereal Disease	Yes No	____________
MALES ONLY		
Prostate Problems	Yes No	____________
Testicular Lumps	Yes No	____________
FEMALES ONLY		
Menstrual Cramps	Yes No	____________
Premenstrual Syndrome	Yes No	____________
Uterine Tumors	Yes No	____________

Pregnancies (# ___)	Yes	No	___
Complicated Pregnancy	Yes	No	___
Menopausal Problems	Yes	No	___
Breast Lumps or Cysts	Yes	No	___
MUSCULOSKELETAL			
Arthritis / Bursitis	Yes	No	___
Low Back Pain / Sciatica	Yes	No	___
Fracture / Dislocation	Yes	No	___
Neck Pain	Yes	No	___
NEUROLOGICAL			
Headaches / Chronic Migraine	Yes	No	___
Epilepsy / Convulsions / Seizures	Yes	No	___
Stroke / Paralysis	Yes	No	___
ENDOCRINE			
Thyroid Disease	Yes	No	___
Diabetes	Yes	No	___
HEMATOLOGICAL			
Anemia / Sickle Cell	Yes	No	___
Cancer	Yes	No	___
Hemophilia / Blood Disorder	Yes	No	___
DERMATOLOGICAL			
Recurring or Chronic Skin Rash	Yes	No	___
Herpes Simplex	Yes	No	___
PSYCHOSOCIAL			
Emotional Problems Which Interfere with Work	Yes	No	___
PRIOR EXPOSURES			
Chemicals / Solvents	Yes	No	___
Asbestos	Yes	No	___
X-ray / Radioactive Chemicals	Yes	No	___

SURGICAL HISTORY

Dates	Type
___	___
___	___
___	___

HOSPITALIZATIONS

Dates	Illnesses / Injuries	Hospital Name / Location
___	___	___
___	___	___
___	___	___

PRESENT OR PAST ILLNESSES OR INJURIES THAT WERE WORK RELATED:

____

Date of Onset: ____________________

Present or Anticipated Limitations: ____________________

OTHER ILLNESSES OR INJURIES THAT WERE NON-WORK RELATED and NOT LISTED ABOVE:

____

Date of Onset: ____________________

Present or Anticipated Limitations: ____________________

I certify that the foregoing statements are true and complete. I understand that falsification of the above information may result in dismissal. I understand that this health screening does not constitute a complete and comprehensive medical exam. I also understand that if any abnormal findings that may interfere with my work performance, or the safety of patients or hospital employees, is identified, this may be discussed with my supervisors and Human Resource personnel when necessary.

Signature: ______________________________ Date: ____________

______________________________ Date: ____________

HUP Occupational Medicine Provider Signature:

The University of Pennsylvania Health System seeks to assist employees with any psychosocial problems or stressors, including, but not limited to: financial problems, substance abuse, problems with spouse or partner, problems with children, problems with parents, or abuse or violence in any personal / domestic relationship. If you are experiencing any of the above and wish to consult a healthcare professional, you may access a confidential counseling service at the Employee Assistance Program (EAP) at no cost by calling 1-888-321-4433. Occupational Medicine clinical staff can provide more information if you would like it.

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UNIVERSITY OF PENNSYLVANIA HEALTH SYSTEM
OCCUPATIONAL MEDICINE

Main # 215-614-0462 Fax # 215-662-6725

HOUSE STAFF INFORMATION

Name:	Medical Record #:
Date of Birth: - -	Need to be seen by MD / NP: ___ Yes ___ No
Emergency Phone #:	Pager #:
Specialty / Department:	Cell Phone #:
Allergies:	Email address:

For *Occupational Medicine* use only: Part II

Immunization Record

Date

Hepatitis B

#1 ____________
#2 ____________
#3 ____________
#4 ____________
#5 ____________
#6 ____________

Tetanus (Td) or Tdap

____
____
____

MMR

#1 ____________
#2 ____________

Measles

#1 ____________
#2 ____________

Mumps

#1 ____________
#2 ____________

Rubella

____

Varicella

#1 ____________
#2 ____________

Vaccinia (Smallpox)

____

Titers

Date **Result**

HepB Surface Antibody

____
____
____
____

HepB Surface Antigen
(not required)

____
____

HepC Antibody
(not required)

____

Measles

____
____

Mumps

____
____

Rubella

____

Varicella

____

Color Vision Testing

____

Tuberculosis

Date **Result**

PPD

#1 ____________
#2 ____________
#3 ____________
#4 ____________
#5 ____________
#6 ____________
#7 ____________
#8 ____________

Chest x-rays

____
____
____

Treatment

____
____

N-95 Respirator Fit Test
Date / Type / Size

____
____
____
____
____
____
____
____

Results of House Staff Day	
Cleared	____
Cleared pending PPD reading	____ Which PPD? ____ #1 or ____ #2
Cleared pending titers	____ Which titers? ____________
Cleared pending other	____________
Not cleared	____ Why?

Follow Up		
Notified by:	Date	Results

Entered into: Pathlore / Lawson ____________ Return ____________ TB ____________

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HOUSE STAFF CHECKLIST

You must have the following documentation for payroll clearance.

Please check each of the following requirements that you have included in your packet.

Measles, Mumps, and Rubella (MMR)

__ 2 doses of MMR vaccines **or**
__ 1 dose of MMR vaccine plus 1 dose each of measles and mumps vaccine **or**
__ 2 doses of measles vaccine plus 2 doses of mumps vaccine and 1 dose of rubella vaccine **or**
__ Documentation of physician-diagnosed disease for each virus **or**
__ Documentation of positive titers for each virus.

Hepatitis B (HepB)

__ 3 doses of vaccines **and**
__ Documentation of positive titer.

Tuberculosis (TB)

__ 2 documented negative PPDs (one within a year and one within one (1) month)
__ Most recent chest xray report (only if prior positive PPD).

Chicken Pox (Varicella)

__ Documentation of 2 doses of vaccine **or**
__ Physician documentation of disease **or**
__ Positive ELISA titer.

Tetanus, Diphtheria, and Pertussis

__ Copies of most recent records if possible.

Mail complete sets of forms and all documentation to:

Dorothy Dragoni, RN, BSN
Compliance Coordinator
Hospital of the University of Pennsylvania
Occupational Medicine
3400 Spruce Street, Ground Floor, Silverstein Building
Philadelphia, PA 19104-4283

Hospital of the University of Pennsylvania
Occupational Medicine

To: University of Pennsylvania Health System Employees

From: Amy J. Behrman, M.D.

Date: February 2, 2009

RE: Tuberculosis Surveillance, Screening and Immunization Requirements

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Tuberculosis

Tuberculosis screening is required for all new employees. TB screening always includes a symptom review, usually includes TB skin testing (PPD), and sometimes includes a chest x-ray. New employees who are eligible for TB skin testing must complete the "two-step" test, which consists of two PPD tests at least several weeks apart. Documentation of recent PPD skin tests can sometimes replace one or both of these, so **be sure to bring this documentation with you.** (Specifically, a PPD recorded within the preceding 12 months can be used for the "first step"; another PPD within 1 month of hire can be used for the "second step".)

Employees who have a history of positive PPDs or who have received the BCG vaccine **must be evaluated in person** in Occupational Medicine. For this evaluation, bring a copy of the report of your most recent chest-x-ray, and any treatment documentation. A recent (<6 months) chest x-ray is required for all PPD-positive or Quantiferon-positive new hires. UPHS does not utilize the quantiferon test for TB screening at this time but we will accept quantiferon results from other institutions. New hires with positive screening tests for latent TB infection will be referred to an Occupational Medicine provider for counseling and treatment as indicated at no charge.

TB screening is also an annual requirement for all UPHS employees. TB screening always involves a symptom review. Skin tests are administered for persons without prior positive reactions. Chest x-rays are required to rule out active TB in persons with new positive

skin tests (per ATS criteria), as well as for prior positives with new symptoms suggestive of active TB infection, or new immune-compromising diseases that raise the risk of reactivation.

Immunizations

Measles, mumps and rubella (MMR) requirements:

CDC guidelines and the JCAHO require you to provide documentation of immunity to measles (rubeola), mumps, and rubella (German measles). Acceptable documentation of immunity is any one of the following:

- Physician-Diagnosed Disease: a signed statement indicating the date you had the disease. "Word of mouth" or letter from a relative is not acceptable.
- Serological Evidence of Immunity: Lab reports or "titers" indicating that you are immune to each of the diseases.
- Documentation of Vaccination: **two** doses of measles, **two** doses of mumps and one dose of rubella must be documented by the administering provider.
- There is no charge to you for immunizations or titers.

Hepatitis B requirements:

For Hepatitis B, OSHA requires documentation of **both** the administration of three doses of vaccine **and** titers demonstrating immunity. If you do not have this documentation, immunizations and/or blood tests are available through Occupational Medicine. If you refuse the vaccines, there must be a documented informed refusal on file in Occupational Medicine.

- Those who refuse may be referred to the attending physician for counseling if needed.
- If the series is complete, but there is no documentation of a positive titer, the Hepatitis B surface antibody titer must be checked.
- Employees with negative titer results will be notified by and requested to return to Occupational Medicine for possible re-immunization and further evaluation.
- There is no charge to you for immunizations or titers.

Varicella (chicken pox) requirements:

Acceptable documentation of immunity is **any one** of the following:

- Physician- Diagnosed Disease: a signed statement indicating the date you had the disease.
- Serological Evidence of Immunity: Lab reports or "titers" **using ELISA method** indicating that you are immune to varicella (chicken pox).
- Documentation of vaccination: (**two** doses at least one month apart).
- There is no charge to you for immunizations or titers.

Tdap (tetanus, diphtheria, and acellular pertussis) requirements:

Tdap is available free of charge to all UPHS employees. All employees who have patient contact must be vaccinated or sign a declination.

Color Vision requirements:

Color vision screening is required for all staff performing point-of-care screening, laboratory workers, pharmacists, and others identified by UPHS HR.

N95 Respirator Fit Testing requirements:

N95 fit testing is required for all staff with direct patient contact. Staff who fail fit-testing with available UPHS N95 respirators will be restricted from caring for patients in airborne isolation until cleared for PAPR use by an Occupational Medicine provider.

Influenza Vaccination:

Influenza vaccine is recommended for all UPHS employees and is available from Occupational Medicine free of charge during every flu season.