Government of South Australia
SA Health

SALHN PRE-EMPLOYMENT HEALTH SCREENING FORM

As part of the SA Health pre-employment program, it is mandatory that all prospective employees who have direct or indirect contact with patients, or contact with blood or other body fluid substances from patients as a result of their work activities are required to complete this Pre-Employment Health Screening Form as part of the selection process and PRIOR to any offer of employment being made. Employment may be delayed if Pre-Employment Health Screening is not completed.

Please complete sections as relevant to the role you have applied (i.e. clinical or non-clinical).

After completion return this questionnaire along with all required documentation and evidence to the Hiring Manager.

Hiring Managers are to email completed form and documentation/evidence to HealthFMCOHSNurse@sa.gov.au

For all enquiries or further clarification, please contact SALHN Worker Health Clinical Nurses

Location:	**Flinders Medical Centre, Room 1K006 (Next to Theo's Coffee Shop)**
Telephone:	**8204 5183 / 8204 5613 / 8404 2788**
Email:	**HealthFMCOHSNurse@sa.gov.au**
Opening times:	**Monday and Tuesday 8am to 4:30pm Wednesday – Thursday 8am to 5pm (*Bookings are essential*)**

Section A: PERSONAL DETAILS

Surname:		**First Name:**			
Preferred Name:		**Gender:**	☐ **M**	☐ **F**	☐ **Other gender identity**
Previous Surname:					
Contact Number (mobile preferred):					
Address:			**Post Code:**		
Preferred Email:			**Date of Birth:**		
Medicare Number:			**IRN:**		
Staff ID (if transferring from another SA Health organisation):					

POSITION APPLIED FOR

Position Applied for:	
• **Occupation (eg Registered Nurse)**	Patient Services Assistant
• **Unit/Ward/Division**	Hotel Services / Corporate
Hiring Manager:	
Proposed Start Date:	

Section B: IMMUNISATION DETAILS

1. Hepatitis B (Clinical roles ONLY)		
Have you completed a full 3 dose course of Hepatitis B vaccine (or 2 doses if given between 11 to 15 years of age) AND had a blood test result showing immunity (hepatitis B surface antibody [anti-HBs] ≥10mIU/mL)? **OR** Have you had resolved HBV infection in the past AND had a blood test to confirm you are immune (hepatitis B core antibody)?	☐ **YES,** you are considered immune to Hepatitis B **Documentation required** ☐ Blood test result indicating positive titre level Date of Test: _____ Result: _____	☐ **NO,** you need to see your GP to commence / complete the Hepatitis B vaccine course. ☐ **DON'T KNOW,** you need to see your GP to have a blood test to check your immunity ▪ If the blood test shows that you are immune you do not need to take further action. ▪ If the blood test does not indicate immunity you will need to see your GP to commence the Hepatitis B vaccine course. ▪ If you have had a full vaccine course but not had a blood test, you should see your GP to have a Hepatitis B booster vaccine and a blood test 4 weeks later.
2. Measles, Mumps, Rubella (MMR) (Clinical & Non-Clinical)		
2 a) Were you born before 1966?	☐ **YES,** MMR vaccination is not required. Go to 3.	☐ **NO,** go to 2 b)
2 b) Do you have evidence of vaccination with at least 2 doses of an MMR vaccine?	☐ **YES,** you are considered immune to MMR. Go to 3. **Documentation required** ☐ Vaccination record for both doses. Dose 1 Date: _____ Dose 2 Date: _____	☐ **NO,** go to 2 c)
2 c) Do you have evidence of immunity to measles, mumps and rubella infections (laboratory evidence of past infection or immunity to MMR)?	☐ **YES,** you are considered immune to measles, mumps and rubella. **Documentation required** ☐ Blood test result indicating immunity for measles, mumps and rubella. Date of Test: _____ Measles Result: _____ Mumps Result: _____ Rubella Result: _____	☐ **NO or DON'T KNOW,** you need to see your GP to commence / complete the MMR vaccine course. ▪ If you are pregnant, planning to get pregnant, or if your immune system is suppressed you should NOT have these vaccines. Discuss this with your GP. ▪ You do NOT need to have a blood test to check immunity following this vaccination course. ▪ If you are confident you have had two doses of MMR vaccine but do not have the documentation, consider seeing your GP to have a blood test to check for immunity before having the 2 dose vaccine course.
3. Chickenpox (Varicella Zoster) (Clinical & Non-Clinical)		
3 a) Have you had two doses of a varicella-containing vaccine (or 1 dose if given before 14 years of age)?	☐ **YES,** you are considered immune to chickenpox (Go to Q4) **Documentation required** ☐ Vaccination record for both doses. Dose 1 Date: _____ Dose 2 Date: _____	☐ **NO go to 3 b)** ▪ You do NOT need to have a blood test to check immunity following this vaccination course.
3 b) Have you had a blood test showing immunity to chickenpox	☐ **YES,** you are considered immune to chickenpox (Go to Q4) **Documentation required** ☐ Blood test result indicating immunity to varicella zoster. Date of Test: _____ Result: _____	☐ **NO or DON'T KNOW,** you need to see your GP for a blood test to see if you are immune to chickenpox ▪ If the blood test result shows you are immune, you do not need to take further action. ▪ If the blood test does not indicate immunity, you need to see your GP to commence / complete the varicella vaccine course.

4. Diphtheria, Tetanus and Pertussis (dTpa) (Clinical & Non-Clinical)		
Have you had a primary course (3 doses) of a diphtheria, tetanus and pertussis containing vaccine as a child? **AND** Had a booster dose of a dTpa vaccine in the last 10 years?	☐ **YES,** you are considered immune to diphtheria, tetanus and pertussis **Documentation required** ☐ Vaccination record for the booster dose. Booster Date: _____	☐ **NO or DON'T KNOW,** you need to see your GP to commence / complete the primary dTpa vaccine course. ▪ If you have had a primary course but no booster in the last 10 years, you need to see your GP for a dTpa booster vaccine. ▪ You do NOT need to have a blood test to check immunity following this vaccination.
5. Influenza (Clinical & Non-Clinical)		
Have you had a seasonal influenza vaccine this year?	☐ **YES,** Date: _____ **Documentation not required**	☐ **NO or DON'T KNOW,** it is highly recommended that you have a seasonal influenza vaccination every year. See your GP to have the vaccine.
6. COVID-19 (Clinical & Non-Clinical)		
Have you completed a 2-dose course and had a booster dose of a COVID-19 vaccine?	☐ **YES,** you are considered immune to COVID-19 **Documentation required** ☐ Vaccination record for both doses. Dose 1 Date: _____ Dose 2 Date: _____ Booster Date: _____	☐ **NO or DON'T KNOW,** you need to provide evidence of 3 documented doses of a Therapeutic Goods Administration (TGA) approved Covid-19 vaccine **OR** provide evidence of 2 doses of a TGA approved COVID-19 vaccine; and have evidence of a booking to have a booster dose of TGA approved COVID-19 vaccine within 4 weeks of becoming eligible as part of the Emergency Management (Healthcare Setting Workers Vaccination No 5)(COVID-19) Direction 2022
7. Poliomyelitis (Clinical & Non-Clinical)		
Have you completed a full 3 dose course of poliomyelitis vaccine (by mouth or by injection) as a child?	☐ **YES,** no further action required **Documentation not required**	☐ **NO or DON'T KNOW,** you need to see your GP for a 3 dose course of inactivated poliomyelitis vaccine (IPV). ▪ You do NOT need to have a blood test to check immunity following this vaccination.
8. Hepatitis A (Only complete this question if you are working or likely to be working in remote Indigenous communities, with Indigenous children or with people with developmental disabilities)		
Have you received 2 doses of Hepatitis A vaccine, at least 6 months apart?	☐ **YES,** you are considered immune to Hepatitis A **Documentation required** ☐ Vaccination record for both doses. Dose 1 Date: _____ Dose 2 Date: _____	☐ **NO or DON'T KNOW,** you need to see your GP to discuss having the 2 dose course of Hepatitis A vaccine. ▪ You do NOT need to have a blood test to check immunity following this vaccination

Applicant Declaration and Consent

I confirm that the information provided in this form is accurate and supported by documented evidence as required. I understand that my participation in the SA Health Immunisation Program is mandatory to reduce the risk of transmission of vaccine preventable diseases to myself and patients. I am aware that my application for employment will not be considered unless all supporting evidence is attached.

I consent to the Worker Health Nurse obtaining information relating to my immunisations, if required, from the SA Health CHRIS 21, IMVS, OACIS and Australian Immunisation register (AIR) databases.

Applicants Name:		**Date:**	
Signature:			

PRE-EMPLOYMENT HEALTH SCREENING FORM Name: _____

Section C: TUBERCULOSIS QUESTIONNAIRE

Please attach evidence of your previous Tuberculosis screening records and relevant blood test results.

Surname:		**First Name:**	
Previous Surname:		**Date of Birth:**	

1: Exposure Risk:

Were you born in Australia? No ☐ Yes ☐ If no, Country of birth? _____

Year of Arrival in Australia? _____ Years Spent in Country of Birth: _____

a. Have you worked or lived outside of Australia for periods of more than 3 months?

☐ Yes (give details from most recent dates below) ☐ No

Country	*Year left*	*Length of Stay*

b. Have you volunteered in a developing nation or travelled in a high TB endemic region where you had close contact amongst locals?

☐ Yes (give details from most recent dates below) ☐ No

Country	*Date*	*Activity*	*Length of Stay*

2: TB Contact History

a. Have you ever been involved in the care of patients with TB, or had close contact with someone who had TB (e.g. family member, friend)?

No ☐ Yes ☐ If yes did you wear an N95 or P2 respirator mask that had been fit tested? No ☐ Yes ☐

Please provide details: _____

3: TB History

a. Have you ever had Tuberculosis in the past? No ☐ Yes ☐ If yes, Were you treated? : No ☐ Yes ☐

If yes, please give details : _____

b. Do you have any of the following symptoms?

Cough No ☐ Yes ☐ If yes, duration (weeks)? _____

Fever No ☐ Yes ☐ If yes, duration (days/weeks? _____

Weight Loss No ☐ Yes ☐ If yes, estimate (kgs)? _____

4: TB Immunisation/Screening Tests (attach supporting evidence)

a. Have you had a BCG vaccination against TB? No ☐ Yes ☐ Date? _____

b. Have you had a Mantoux Skin Test? No ☐ Yes ☐ Result in mm? _____ Date? _____

c. Have you had a blood test for TB? No ☐ Yes ☐ Result? _____ Date? _____

d. Have you ever had a chest x-ray? No ☐ Yes ☐ Result? _____ Date? _____

e. Have you ever passed an N95/P2 mask fit test? No ☐ Yes ☐ Mask type? _____ Date? _____

Applicant Consent

I consent to the Worker Health Nurse obtaining information relating to previous Mantoux skin tests, chest x-rays and TB screening history from the SA TB Services Chest Clinic.

Applicants Signature: **Date:**

Section D: OTHER HEALTH INFORMATION

1. Do you have or have you ever had a blood borne virus (i.e. Hepatitis B, Hepatitis C or HIV) No ☐ Yes ☐

If yes, please provide details:

2. Do you have a skin condition that affects your hands or forearms (e.g. dermatitis, eczema or psoriasis) No ☐ Yes ☐

If yes, please provide details:

3. Do you have any allergies to latex, chemicals or substances? No ☐ Yes ☐

If yes, please provide details:

4. Do you have a medical condition or are you having treatment that might suppress your immunity? No ☐ Yes ☐

If yes, please provide details:

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Health Care Worker Immunisation Screening and Tuberculosis Questionnaire
Section 4: Immunisation Compliance

For completion by the Worker Health Nurse only

Surname:	**First Name:**
Position Applied for:	**Date of Birth:**
Commencement Date:	**Staff ID:**
Hiring Manager:	
Immunisation Risk Category:	

☐ Applicant is compliant with Immunisation Screening

☐ Hiring manager emailed with outcome of Immunisation Screening

☐ Information entered on CHRIS 21 database

WHS Nurse Name: **Signature:** **Date:**

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Health Care Worker Immunisation Screening and Tuberculosis Questionnaire
Section 4: Immunisation Compliance

Immunisation/Test information for data entry onto CHRIS 21

Hepatitis B:
MMR:
Varicella:
dTpa:
TB Questionnaire:
Mantoux / IGRA / X-Ray:
Flu:
COVID-19:
Fit Test:

☐ Emailed manager/applicant with outcome of immunisation screening and further requirements
Date first emailed: _____

Additional WHS Notes: (please date and sign each note)