INSTRUCTIONS FOR COMPLETING THE IMMUNISATION QUESTIONNAIRE AND CONSENT FORM

1. Print out the Immunisation Questionnaire & Consent Form.

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

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

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

5. Place the completed form in a sealed envelope and mark it “confidential.”

6. Send (via internal mail) to:

   Occupational Health Nurse Consultant
   Occupational Health and Safety
   30 Research Way
   Clayton Campus

When the form is received at Occupational Health and Safety you will then be notified (by mail) with details 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.
**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

<table>
<thead>
<tr>
<th>Surname</th>
<th>Given names</th>
<th>Date of Birth</th>
<th>M</th>
<th>F</th>
<th>I.D. Number</th>
<th>Tel</th>
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<table>
<thead>
<tr>
<th>Department</th>
<th>Campus</th>
<th>Building</th>
<th>Room number</th>
<th>Cost Centre</th>
<th>Fund No.</th>
<th>Dept contact name</th>
<th>Dept contact signature</th>
<th>Dept contact telephone</th>
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### 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:

1. **YES** **NO** Have you ever had - tuberculosis
   - [ ] serious chest infections
   - [ ] exposure to anyone known or suspected to have tuberculosis
   - [ ] worked or lived overseas for more than 3 months 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. **YES** **NO** Do you currently have - any allergies (please list and include reaction)
   - [ ] immune system deficiency
   - [ ] any illness

5. **YES** **NO** Are you taking any medication (e.g. tablets, capsules, puffers, creams)?
   - [ ] If yes, please list

6. **YES** **NO** Are you pregnant, trying to become pregnant or breast feeding?

7. **YES** **NO** 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
### Surveillance Program

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Date</th>
<th>Result</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Quantiferon Test</td>
<td>.../.../......</td>
<td>...</td>
<td>...</td>
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<tr>
<td>Date of Chest Xray</td>
<td>.../.../......</td>
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<td>...</td>
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<tr>
<td>Date of Sputum test</td>
<td>.../.../......</td>
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<td>...</td>
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<tr>
<td>Date of commencement of treatment</td>
<td>.../.../......</td>
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<tr>
<td>Date of completion of treatment</td>
<td>.../.../......</td>
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<tr>
<td>Date of sputum test (3 months after completion of treatment)</td>
<td>.../.../......</td>
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</table>

- Retesting required for Quantiferon Tb Gold test: Date .../.../......
- Reason: ...

Chest Xray & Referral to Infectious Disease Specialist required:
- Yes [ ]
- No [ ]

Retesting required for Quantiferon Tb Gold test: Date .../.../......
- Reason: ...

Chest Xray & Referral to Infectious Disease Specialist required:
- Yes [ ]
- No [ ]

Retesting required for Quantiferon Tb Gold test: Date .../.../......
- Reason: ...

Chest Xray & Referral to Infectious Disease Specialist required:
- Yes [ ]
- No [ ]