

HEPATITIS B IMMUNISATION QUESTIONNAIRE & CONSENT FORM

INSTRUCTIONS FOR COMPLETING THE FORM BELOW

1. Print out the Hepatitis B 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
26 Research Way
Clayton Campus

When the form is received at OH&S you will then be notified (by mail) with details to arrange the necessary immunisation.

Please call one of the Occupational Health Nurse Consultants at OH&S on 9905 1014 if you have any queries.



HEPATITIS B IMMUNISATION QUESTIONNAIRE & CONSENT FORM

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

Part 1 - Pre-Immunisation 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 Immunisation and Medical History

Reason for immunisation: (please tick) ✓ [] First Aider [] Working with human blood and bodily fluids [] Potential exposure to sewerage
[] Working with animals (please list below) [] Water/Environmental studies
[] Gardeners [] Childcare
[] Responsible for needle syringe disposal
[] Other (please list)

Please answer "yes" or "no" to the following questions:

1. Have you previously been immunised against Hepatitis B? YES [] NO []
If yes, please give approximate dates:
1st immunisation -
2nd immunisation -
3rd immunisation -
Blood test date -
Blood test result -
2. Have you ever had - hepatitis [] []
- jaundice [] []
3. Do you currently have - yeast hypersensitivity [] []
- any illness [] []
If so, please list
- immune system deficiency [] []
- any allergies (please list and include reaction) [] []
4. Are you taking any medication (e.g. tablets, capsules, puffers, creams)? [] []
If so, please list
5. Are you pregnant, trying to become pregnant or breast feeding? [] []
6. Do you have any concerns about your health? [] []
If so, please list.....

Part 3 - Declaration

- 1. I understand that Hepatitis B immunisation will, in most cases, result in immunity to the Hepatitis B virus. I understand that the risk of adverse reactions is very low. Soreness at the injection site, more rarely aches and fever and very rarely hypersensitivity may occur.
2. I understand that the effects of the vaccine on pregnancy are unknown and therefore becoming pregnant during the course of injections is inadvisable.
3. I understand that if I have had previous Hepatitis B immunisation, a blood test may be required to determine antibody status.
4. I understand that Part 4 of this form will be completed by the clinic which performs the immunisation. Once the course of injections and the blood tests have been completed, this form will be automatically forwarded by the immunising clinic to OHS.
5. I understand that my Manager/Supervisor may be notified regarding my immunisation status.
6. I believe the answers to the above are correct and I give my consent to be immunised with Hepatitis B and to have a blood sample taken for antibody assay one month after the last injection.

Signed..... Date.....

Part 4 - Immunisation Record (To be completed by Doctor/Nurse)

	Batch	Expiry date	Given by	Date
Injection 1 .....	.....	.....	.....	...../...../.....
Injection 2 (One month after injection 1) .....	.....	.....	.....	...../...../.....
Injection 3 (Six months after injection 1) .....	.....	.....	.....	...../...../.....
Blood Test Result (One month after injection 3) _____IU	Adequate ¹ <input type="checkbox"/>	Inadequate ² <input type="checkbox"/>/...../.....	

If inadequate seroconversion

1. Double dose

	Batch	Expiry date	Given by	Date
Injection 4/...../.....
Injection 5/...../.....
Blood Test Result (One month after double dose injection 4 & 5)	Adequate ¹ <input type="checkbox"/>	Inadequate ² <input type="checkbox"/>/...../.....

OR

2. Further 3 doses at monthly intervals

	Batch	Expiry date	Given by	Date
Injection 4 .....	.....	.....	.....	...../...../.....
Injection 5 .....	.....	.....	.....	...../...../.....
Injection 6 .....	.....	.....	.....	...../...../.....
Blood Test Result (One month after injection 6) _____IU	Adequate ¹ <input type="checkbox"/>	Inadequate ² <input type="checkbox"/>/...../.....	

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.