Wellstar HEALTH SYSTEM

Annual Health Assessment for Hospice and Home Health Team Members

Name _____ Employee ID _____ Date of birth _____

Address _____ City _____ State _____ ZIP _____

Phone _____

Have you had a name change in the last 24 months? (if yes, please list) _____

Facility Name _____ Job Title _____ Supervisor/Manager _____

Are you currently experiencing any of the following TB symptoms?

Cough, unexplained persistent for more than two weeks	☐ Yes	☐ No
Unusual fatigue	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Unexplained fever	☐ Yes	☐ No
Unexplained weight loss	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No
Have you tested Positive or Reactive to the TB Skin Test in the past?	☐ Yes	☐ No
Have you received INH (Isoniazid) or other treatment?	☐ Yes	☐ No
Do you have a current chest X-ray on file in Employee Health?	☐ Yes	☐ No

N95 TB Mask (omit question if N95 Mask usage is not required for your job duties)

Have you lost or gained more than 25 pounds since you were last fit tested for the N95 mask?	☐ Yes	☐ No
Have you had any cosmetic surgery, facial scarring, installation of denture, or absence of denture since your last fit test?	☐ Yes	☐ No
Do you have any difficulty wearing the N95 mask?	☐ Yes	☐ No

TD and Tdap

Have you had a Tetanus, Diphtheria and Pertussis vaccination (Tdap) within the last 10 years?	☐ Yes	☐ No
Have you had a Tetanus, Diphtheria vaccination (TD) within the last 10 years?	☐ Yes	☐ No

Hepatitis B (omit question if HepB vaccination is not required for your job duties)

Series completed	☐ Yes	☐ No
Series in progress	☐ Yes	☐ No

It is required by Hospice State Regulations that all hospice and home health team members and providers attest that they are free from communicable diseases; i.e. Hepatitis B and Tuberculosis.

I, _____ certify that I am currently free from the communicable diseases as indicated by the state laws for hospice team members.

Team Member Signature Date

Health Nurse Signature Date

Clinician's Signature Date

☐ Data entered into Employee Health Database