The Reading Hospital & Medical Center

TST

Tuberculin Skin Test

Volunteers

It is mandatory before being allowed to volunteer that you have a TST (Formally called PPD) placed. First year volunteers need a two step TST while returning volunteers need just their annual TST placed.

The TSTs are administered free of charge to volunteers by Employee/Occupational Health Services.

Appointments are necessary for placement and reading of your TST. Please call the office convenient to you.

Employee Health Services, Doctor's Office Building, Suite 2020, 7th Ave West Reading 610-988-8499

Occupational Health Services, 1000 Tuckerton Court, Muhlenberg Township 610-988-4000

No TSTs are administered on Thursdays

You must have your arm read within 48-72 hours of the placement of your TST or you will have to repeat the entire test. First time volunteers are rescheduled the following week for step 2 of their TST.

EHS7/09

INITIAL Immunity Assessment for Associates not employed by TRHMC

Name:	_____	DOB:	_____
Address:	_____	Phone:	_____
	_____	Alt. Phone:	_____
Employer:	_____	SSN:	_____
Job Title:	_____		_____
Allergies:	_____		
	If none, write 'None.' Include any allergy/sensitivity to any rubber or latex product.		

Note: When antibody testing is needed, qualitative (e.g. "positive" or "negative") results are acceptable. <u>Complete dates are required – MM/DD/YY</u>. <u>Attach supporting documentation for each item.

☐ Tuberculosis Surveillance **(attach documentation of placement, reading, measured result)**
- Two negative annual TSTs, one within past year _____ -_____ OR
- A negative 2-step TST within past year _____ - _____
- **If history of positive TST**, attach report of chest x-ray _____(date within past three months)

☐ <u>Hepatitis B</u>
- Three Hep B Vaccine dates _____ - _____ - _____ OR
- Signed declination (attach declination) OR
- If you have had Hepatitis B, documentation of Positive Hep B Surface Antigen

☐ <u>Measles, Mumps, Rubella (MMR)</u> - **<u>History of disease is not acceptable proof of immunity</u>**.
- Two dates of MMR vaccinations _____ - _____OR
- Positive antibodies for all three diseases

☐ <u>Varicella (Chickenpox)</u> - **<u>History of disease is not acceptable proof of immunity.</u>**
- Dates of TWO varicella vaccines _____ - _____ OR
- One Varicella vaccine_____ and one Zoster vaccine_____ OR
- Positive varicella antibody

☐ Influenza – MANDATORY
- Immunization with current seasonal influenza vaccine OR
- Signed Declination form

☐ <u>Pneumovax</u> (Required ONLY for those working in Post Acute)
- Date of pneumonia vaccine _____ OR
- Signed declination statement

☐ <u>Tetanus, Diphtheria, Acellular Pertussis</u> (Recommended, but not required)
- Date of Tdap vaccine _____

☐ 5-Panel forensic urine drug screen performed within last 30 days - attach negative result (for certain associates)

I acknowledge that the above information is complete and accurate to the best of my knowledge.

Signature:_____ Date _____

ANNUAL Immunity Assessment for Non-Employed Associates of TRHMC

Name:	_____	DOB:	_____
Address:	_____	Phone:	_____
	_____	Alt. Phone:	_____
Employer:	_____	SSN:	_____
Job Title:	_____		_____
Allergies:	_____		
	If none, write 'None.' Include any allergy/sensitivity to any rubber or latex product.		

☐ Tuberculosis Surveillance – due during anniversary month of entry **(attach documentation of placement, reading, measured result)**

- Tuberculosis Skin Test (TST) date _____ OR
- If positive TST, Annual TB Symptom Screen (attach completed Screening)

☐ Seasonal influenza

- Annual Seasonal influenza vaccine OR
- Seasonal influenza declination (attach completed form)

I acknowledge that the above information is complete and accurate to the best of my knowledge.

Signature:_____ Date _____

The Reading Hospital and Medical Center
Occupational Health Services
AUTHORIZATION FOR TESTING AND RELEASE OF INFORMATION

Patient Name: _____ **Social Security Number:** _____ **Date:** _____

Date of Birth: _____ **Mar Stat:** _____ **Race:** _____ **Sex:** _____ **Home Phone:** _____

Patient Address: _____

Preferred Language: __ English __ Spanish __Other:_____

Company to pay for service(s): _____ **If YOU are paying for service(s), check here:** ❑

ALLERGIES: _____ **Do you have an allergy/sensitivity to any rubber or latex product?** [ ] No [ ]Yes

Test(s) Requested

- ❑ Urine Drug Test*
- ❑ Breath Alcohol Test
- ❑ Physical Examination**
- ❑ Urinalysis
- ❑ Hair Collection
- ❑ X-Rays - _____
- ❑ Immunization - _____
- ❑ Pulmonary Function Test
- ❑ Audiogram
- ❑ EKG
- ❑ Blood Work - _____
- ❑ PPD
- ❑ Other - _____

Reason for Test(s)

- ❑ Pre-employment / Pre-placement
- ❑ Re-certification / Periodic *(circle one)*
- ❑ Random
- ❑ Post Accident / Post-injury *(circle one)*
- ❑ Reasonable Cause
- ❑ Follow Up
- ❑ Other - _____

I understand that the employer, named above, has requested that I submit to the tests and/or examination noted, hereinafter referred to as tests. I voluntarily submit to the tests and authorize The Reading Hospital & Medical Center to obtain any appropriate specimen(s) for performing the tests. I also authorize the release of the result(s) of the tests to the employer or its designee.

If any medical problems are identified at the time of these tests, I understand that the employer will be advised of such, and that the employer may advise me to consult with my personal physician. If I have any questions about the results of my tests, I understand that I must follow-up with the employer.

* On occasions when I consent to drug testing pursuant to Federal Motor Carrier Safety Regulations or when I consent to drug testing requested by the employer as part of my employment or pre-employment testing, I understand that the results will be forwarded by the laboratory only to the Medical Review Officer (MRO) signing the report. The MRO will report only to the above-noted employer or its designee whether the test results were negative or positive. I also understand I will be given reasonable opportunity to confer with the MRO before a positive test result is reported to the employer. I further understand that the results will not be released to any additional parties without my written permission.

** On occasions when I consent to a physical examination, I understand that the examination performed is an independent medical examination and is applicable to the job requirements only. This examination should not be considered a substitute for a physical examination to be completed by my personal physician.

_____	_____	_____	_____
Signature of Examinee or Legal Guardian (if under 18 years old)	**Date**	**Signature of Witness**	**Date**

FOR OCCUPATIONAL HEALTH USE ONLY - If the person refuses to submit to testing, complete the following information.

_____	_____	_____
Date	Time	Reason

_____	_____
Signature of Staff Member	Signature of Person Refusing Tests

Results Called: _____ **Results Sent:** _____

Date Contact Initials Date Initials

Notes: _____

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