Tuberculosis (TB) Assessment Tool

Please download and save form prior to filling. Refer below to Appendix 1 - How to fill & sign PDF fillable forms

Personal Information

Family Name: Enter Family Name

Given Name(s): Enter Given Name(s)

Date of Birth:

Phone Number: Select — Enter Phone No.

Medicare Number: Enter Medicare No.

Position on card (number next to): Enter Position No.

Expiry Date:

Address (street number / name / suburb / postcode)

St No. | Enter Street Name | Enter Suburb | Postcode

Email: Enter Email Address

Employer: Enter Employer Name Here

AGS Number: Enter AGS Number

Current Position / Role: Select Current Position / Role

Block No.: Select Block No.

*Category: Select Current Category

*Appendix 1: What category am I?

Signature: SIGN HERE

Date:

Please complete all questions in Parts A, B and C.

Part A: Symptoms requiring investigation to exclude active TB disease

Do you currently have any of the following symptoms that are not related to an existing diagnosis or condition that is being managed with a doctor?	Yes	No
1. Cough for more than 2 weeks?	☐	☐
2. Episodes of haemoptysis (coughing blood) in past month?	☐	☐
3. Unexplained fevers, chills or night sweats in the past month?	☐	☐
4. Significant* unexpected weight loss over the past 3 months? **loss of more than 5% of body weight*	☐	☐

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Given Name(s): Enter Given Name(s)

AGS Number: Enter AGS Number

Part B: Previous TB treatment or TB screening or increased susceptibility	Yes	No
1. Have you ever been treated for active TB disease or latent TB infection (LTBI)? If Yes, please state the year and country where you were treated and provide documentation (if available) Year: Country: Enter Country	☐	☐
2. Have you ever had a positive TB skin test (TST) or blood test (IGRA or QuantiFERON TB Gold+)? If yes, please provide copies of TB test results.	☐	☐
3. Do you have any medical conditions that affect your immune system? e.g. cancer, HIV, auto-immune conditions such as rheumatoid arthritis, renal disease	☐	☐
4. Are you on any regular medications that suppress your immune system? e.g. TNF alpha inhibitors, high dose predisolone Please provide details here: Enter Medications	☐	☐

Part C: Possible TB exposure risk history		
The following questions explore possible previous exposure to TB		
1. In what country were you born? Enter Country of Birth If overseas, when did you migrate to Australia?		
First Assessment Only 1a. Is your coutry of birth on the list of high-TB-incidence countries? For up-to-date list of high TB incidence countries, please go to: https://www.health.nsw.gov.au/Infectious/tuberculosis/Pages/high-incidence-countries.aspx	**Yes** ☐	**No** ☐
1b. If Yes, as part of your visa medical assessment, did you have a negative TB skin test (TST) or blood test (IGRA or QuantiFERON TB Gold+)? *If yes, please provide a copy of the result	☐	☐
2. Have you had direct contact with a person with infectious pulmonary TB without adequate personal protective equipment and did not complete contact screening?	**Yes** ☐	**No** ☐
3. Have you ever visited or lived in a country/ies with a high TB incidence in your life (ONLY REQUIRED for first assessment) OR since your last TB Assessment? If Yes, please list below the countries you have visited, the year of travel and duration of stay.	☐	☐

Country Visisted	Year of travel	Duration of stay *(specify d/w/m)*	Country Visited	Year of travel	Duration of stay *(specify d/w/m)*
Country Visited		Specify D/W/M	Country Visited		Specify D/W/M
Country Visited		Specify D/W/M	Country Visited		Specify D/W/M
Country Visited		Specify D/W/M	Country Visited		Specify D/W/M
Country Visited		Specify D/W/M	Country Visited		Specify D/W/M
Country Visited		Specify D/W/M	Country Visited		Specify D/W/M

If more space is required, please complete details on a separate page and upload with this form.

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Family Name

Enter Family Name

Given Name(s)

Enter Given Name(s)

AGS Number

Enter AGS Number

Other relevant information to assist with determining TB risk

E.g. pre-migration TB screening-CXR reported as normal and negative IGRA on

Date

Enter other relevant information here

All existing and new members need to submit this form to the provider of Occupational Assessment, Screening and Immunisation OR the ACTAS Infection Prevention and Control Officer (IPCO). The provider or IPCO will assess this form and determine whether TB screening or TB clinical review is required.

Privacy Notice: Personal information about members collected by ACTAS is handled in accordance with the Health Records and Information Privacy Act 2002. ACTAS is collecting your personal information to meet its obligations to protect the public and to provide a safe workplace as per the current Occupational Assessment Screening and Vaccination Against Specified Infectious Diseases (OASVASID) Standard Operating Procedure (SOP). All personal information will be securely stored, and reasonable steps will be taken to keep it accurate, complete and up to date. Personal information recorded on this form will not be disclosed to ACTAS managers or third parties unless the disclosure is authorised or required by or under law. If you choose not to provide your personal information, you will not meet the requirements of the OASVASID SOP.

For Official Use Only

Please refer to XXXX – TB Assessment Decision Support Tool for guidance on documenting outcomes from this TB Assessment:

- ☐ TB Compliant
- ☐ Advice sought from local TB service/chest clinic
- ☐ TB Screening required – referred to GP or local TB service/chest clinic
- ☐ TB Clinical Review required – referred to local TB service/chest clinic
- ☐ Other

Enter description of other

Name of assessor and role

Enter Name & Role of Assessor

Contact Number

Enter Contact Ph Number

Health Agency/District/Network

Enter Health Agency/District/Network

Date of assessment

APPENDIX 1: Fill and Sign PDF Fillable Forms & What Category am I?

How do I fill and sign PDF fillable forms on my computer?

1. **Make sure Adobe Acrobat Reader software is installed on your personal computer/device**
   If Acrobat Reader isn't already installed, you can **download PDF reader**. Alternatively, you can use Adobe Fill & Sign app available on App Store for iPhone or iPad and Google Play
   NOTE: You can not download PDF reader on ACT Government devices without permission.

2. **Download the form**
   Save the form as a PDF file, either on your computer's desktop or in a folder. This is important as certain web browsers won't save your information after editing.

3. **Clicking on a hyperlink within the form**
   Right click the hyperlink and choose 'open link in new window' to avoid losing already filled information.

4. **Open the form**
   You might need to right-click your mouse or track-pad and choose 'Open with > Adobe Acrobat Reader'. Once open, consider enlarging the page to assist navigating through the field options.

5. **Type your details into the form**
   The form is an 'editable' PDF, which means you can click on any of the fields highlighted in grey to start filling in the form.

6. **Sign the form**
   Once you have completed the form, you will need to sign it electronically with the "Fill & Sign" function. Click the "Sign" icon on the top menu bar and select "Add Signature" then "Draw" to draw your signature. Once you're happy with your signature, click "Apply" to add it to the signature sections (grey boxes) of the document. Select close once you have added your signature. If you make a mistake, click on signature and choose delete. Alternatively, use the eraser option to remove and then start again.

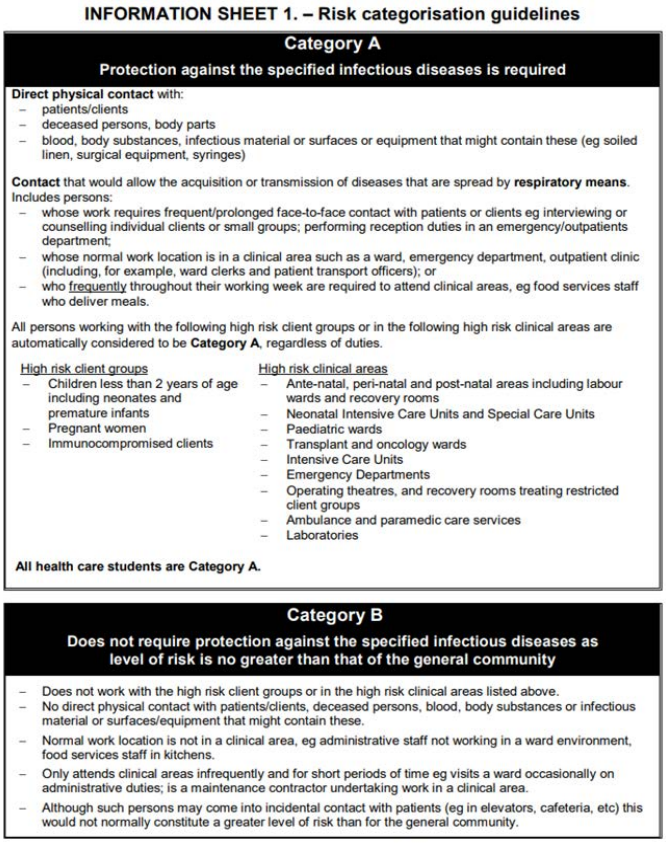
7. **Save your form**
   Once you have completed all sections of the form, save the PDF file. This will ensure all your information is retained.

What Category am I?

ACTAS Category A position/roles:

- Intensive Care Paramedic (ICP)
- ICP/Extended Care Paramedic (ECP)
- Ambulance Paramedic (AP)
- AP2/ECP
- Graduate Paramedic Intern
- Patient Transport Officer
- Communications Centre
- Operational Support

Category A-EPP: The Flight Intensive Care Paramedic position is sub-classified as Category A-EPP. This is due to their scope of practice including finger thoracostomy.



INFORMATION SHEET 1. – Risk categorisation guidelines

Category A

Protection against the specified infectious diseases is required

Direct physical contact with:
- patients/clients
- deceased persons, body parts
- blood, body substances, infectious material or surfaces or equipment that might contain these (eg soiled linen, surgical equipment, syringes)

Contact that would allow the acquisition or transmission of diseases that are spread by **respiratory means**. Includes persons:
- whose work requires frequent/prolonged face-to-face contact with patients or clients eg interviewing or counselling individual clients or small groups; performing reception duties in an emergency/outpatients department;
- whose normal work location is in a clinical area such as a ward, emergency department, outpatient clinic (including, for example, ward clerks and patient transport officers); or
- who frequently throughout their working week are required to attend clinical areas, eg food services staff who deliver meals.

All persons working with the following high risk client groups or in the following high risk clinical areas are automatically considered to be **Category A**, regardless of duties.

High risk client groups
- Children less than 2 years of age including neonates and premature infants
- Pregnant women
- Immunocompromised clients

High risk clinical areas
- Ante-natal, peri-natal and post-natal areas including labour wards and recovery rooms
- Neonatal Intensive Care Units and Special Care Units
- Paediatric wards
- Transplant and oncology wards
- Intensive Care Units
- Emergency Departments
- Operating theatres, and recovery rooms treating restricted client groups
- Ambulance and paramedic care services
- Laboratories

All health care students are Category A.

Category B

Does not require protection against the specified infectious diseases as level of risk is no greater than that of the general community

- Does not work with the high risk client groups or in the high risk clinical areas listed above.
- No direct physical contact with patients/clients, deceased persons, blood, body substances or infectious material or surfaces/equipment that might contain these.
- Normal work location is not in a clinical area, eg administrative staff not working in a ward environment, food services staff in kitchens.
- Only attends clinical areas infrequently and for short periods of time eg visits a ward occasionally on administrative duties; is a maintenance contractor undertaking work in a clinical area.
- Although such persons may come into incidental contact with patients (eg in elevators, cafeteria, etc) this would not normally constitute a greater level of risk than for the general community.