Post-Offer Screening Patient Contact Form
UF Employee/Volunteer

Patient Contact review appointments must be scheduled. Call UF Occupational Medicine clinic @ Shands to set up an appointment. 352-294-5700

The information requested on these pages is necessary in order to minimize any occupational risks to you and to insure that you can safely perform the essential functions of your new job. Medical History information on this form will be kept in a confidential file at the SHCC, and will not be shared with your Employer, Program or Director without your written permission/consent. Immunization Documentation may be shared with your Program and the Occupational Medicine Department of your work site.

Must complete ALL sections. Please print legibly.

Name: ________________________________ **Date of Birth:** ______________
(Last, First, Middle Initial) (Mm / dd / yy)

UF ID #: __________________________ **Gender at Birth: Male** ____ **Female** _____

Email Address: ______________________________ **Cell number:** ______________________

Address: ____

City, State Zip: ____

Work Site - Gainesville: ______ **Jacksonville:** ______ **Other:** __________________________

Department: ____________________ **Supervisor/Program Director:** _________________

Position #: ______________________ **Job Title:** ______________________________________

Section I - Medical History

Do you have now, have you ever had, or have you received treatment for the following:

Yes	No		If *YES* use as many lines below as needed to explain with dates.
☐	☐	Alcohol abuse/alcoholism	______________________
☐	☐	Allergies to medications/foods	______________________
☐	☐	Asthma	______________________
☐	☐	Back or neck injury	______________________
☐	☐	Carpal Tunnel syndrome	______________________
☐	☐	Chronic back pain	______________________
☐	☐	Current Medications: doses and Frequency	______________________
☐	☐	Diabetes (type)	______________________
☐	☐	Difficulty hearing/hearing aides	______________________
☐	☐	Drug abuse/addiction	
☐	☐	Hospitalizations/Surgeries	______________________
☐	☐	Immunosuppression	______________________
☐	☐	Infectious Disease	______________________

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Yes	No		If ***YES*** use as many lines below as needed to explain
☐	☐	Latex allergy or other skin sensitivities	______________________
☐	☐	Other hand/wrist problems	______________________
☐	☐	Other liver disease (type)	______________________
☐	☐	Seizures	______________________
☐	☐	Tuberculosis	______________________
☐	☐	Visual loss (one or both eyes)	______________________

Have you ever had a work-related illness or injury? Yes ___ No ___

If yes, explain: ____

Have you been cleared by a medical provider to return to full duty without restrictions? Yes ___ No ___

Date: ____

Are you currently recovering from any significant illness, surgery or injury? Yes ___ No ____

If yes, explain: ____

Have you been cleared by a medical provider to return to full duty without restrictions? Yes ___ No ___

Date: ____

Do you have any medical or psychological conditions that you feel may prevent you from completely and safely performing the duties outlined in your job description, or do you require/request any modifications to your job duties? Yes ___ No ___ If yes, explain: ______________________

____

Would you like to speak to a UF Occupational Medicine clinician about any of the information you have given above? Yes ___ No ___ If yes, daytime phone (   ) ______________________

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Print Name: ______________________ **UFID#:** ______________________

Signature: ______________________ **Date**: ______________________

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Name: ________________________________ DOB: _______________ UFID: ________________

Required Immunizations

Positive titer for immunity will substitute for shots on numbers 1-4. Titers must have lab attached

	Mo/Day/Year	Mo/Day/Year	Mo/Day/Year	Titer Date & Result*
1.**Measles** (2 doses after 1st birthday)				
2.**Mumps** (2 doses after 1st birthday)				
3.**Rubella** (2 doses after 1st birthday)				
4.**Varicella** (Chicken Pox 2 doses after 1st birthday)				
5.**Hepatitis B** (vaccination dates required)				**Titer does not substitute**
6.**Tdap** (adult booster within 10 years)				

Required Tuberculosis Screening

Tuberculosis screening **completed within 12 months prior to start date** must be either: Two negative TST's** (PPD's) or a negative Interferon Assay BCG is not a substitute for a previous positive screening for TB. If there is a history of a prior positive TB screening result then see below.

PPD** #1 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
PPD** #1 Skin Test (Tuberculosis Screening)	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (instead of PPD's)		Date	Result	

(OR)

If past positive PPD or positive Interferon Assay you must submit documentation: 1.) Original report of positive TST, (BCG is not a substitute for a previous positive screening for TB), 2.) Chest x-ray **within 12 months prior to start date** (record below), and 3.) UF TB surveillance form. All 3 items must be submitted.

Past Positive PPD skin Test	Date Placed	Date Read	MM	Neg or Pos
Interferon-based Assay* (attach copy of lab)		Date	Result	
CXR* (only if past positive PPD)		Date	Result	

***All titers, assays, and chest x-rays must have results attached**

**TST's (PPD) placements must be at least 7 days apart and cannot be placed within 28 days after a live virus immunization like measles, mumps, rubella, or varicella. TST's (PPD's) must be read within 48-72 hours after placement.

Official Office Stamp Here Authorized Signature Date

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must appear here or this form will not be approved. You or a family member may not be the authorized signator of your own form.

University of Florida
Occupational Medicine Program
Email: occmedclinic-riskassessment@ahc.ufl.edu

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