OCCUPATIONAL HEALTH
&
EMPLOYEE HEALTH
Gengras Medical Building
Suite 4320
The enclosed packet has been designed to expedite your Urine Drug Screen and Preplacement Physical appointment in Occupational Health. Your appointment time is a reserved appointment, please arrival at least 15 minutes early. **Late arrivals may need to be rescheduled.**

Please complete the packet IN ITS ENTIRETY prior to attending your appointment.

The following materials are included in this folder and should be completed and brought to Occupational / Employee Health on the day of your scheduled appointment:

1. Urine Drug Testing Procedure
2. Employee Health History Questionnaire
3. Employee Health and Respiratory History Form (for Fit testing, where applicable)
4. TB Skin Test Questionnaire

Please bring any prior immunization records with you if they are available. You WILL NOT be cleared for orientation unless all of the requirements are completed and documents received. Directions are enclosed for your convenience. If you have any questions, please call us:

Saint Francis Hospital & Medical Center, Department of Occupational & Employee Health: (860) 714-4270
Contact Information

The Medical Review Officer may need to contact you for more information to properly interpret your drug test result.

Name________________________________________________

Social Security Number_________________________________

Address_________________________________________________________________________________

street    town    state   zip code

Home telephone number ____________________________________

area code  number

Please provide a phone number where you can be reached on weekdays between 8am-4pm.

________________________________

area code number

Consent for Urine Drug Testing

I hereby give my voluntary consent for a urine sample to be collected from me and submitted for drug testing. I understand that the specimen will be collected using a chain of custody procedure and will be sent to a NIDA-approved laboratory for testing. The laboratory results will be reviewed by a Medical Review Officer who may contact me to discuss the results and to obtain further information. I give permission to the Medical Review Officer to contact my personal physicians to verify medical or prescription information.

I understand that the Medical Review Officer will make a final determination of the test result and will notify Human Resources of this result. If my urine is determined to be “Positive,” I understand that I have 72 hours to request a re-analysis of the same specimen or a split specimen according to company policy at my own cost.

I have read the Urine Drug Screening Procedure Information Sheet and this Consent Form. Any questions that I had regarding this procedure have been answered to my satisfaction.

_____________________________

Signature

_____________________________

Witness

_____________________________

Date
You have been asked by your employer or prospective employer to provide a urine specimen for drug testing. We would like to explain our procedure to you.

When you come to our Center, you will be asked to show a photo-identification to the health care professional who collects your specimen. That person will be wearing their Saint Francis Hospital photo-identification. Your driver’s license is the best form of identification. A military ID, passport or school photo-ID is also acceptable. **It CANNOT be an expired ID.**

Your urine specimen will be collected according to procedures described by the National Institute on Drug Abuse (NIDA) and sent to a NIDA-approved laboratory for analysis.

You will be asked to remove your outer garments and leave them along with any personal belongings outside the bathroom. Valuables such as your wallet or pocketbook will be locked in a cabinet outside the bathroom door.

You will be given a container in which to urinate. You will wash and dry your hands in the collector’s presence both before and after producing the urine specimen. After washing your hands, the collector will turn off the water in the sink. You will then urinate in the privacy of a locked bathroom without observation. A bluing agent has been added to the toilet water. You will be told not to flush the toilet after you void.

You must produce at least 45-60 cc of urine in the container that we give you. If you feel that you cannot produce this amount of urine, tell the collector. If you do produce a specimen that is less than one ounce, it will be discarded. You will have up to 3 hours to produce a sufficient new specimen. You will be provided with up to 40 ounces of fluid to drink. During this time, you must remain at the Center.

Within four minutes after you produce the urine specimen, the collector will measure the urine temperature. If the temperature is outside the acceptable range, the collector will take your temperature orally. The collector will inspect the specimen for color, appearance, and signs of contamination.

You and the collector will complete the process together by sealing and labeling the specimen bottle. You will initial the label and sign and date the custody form.

The urine specimen will be sent to a NIDA-approved laboratory for analysis. The urine will be tested for the following drugs at the thresholds indicated:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamines</td>
<td>1000 ng / ml</td>
</tr>
<tr>
<td>Cocaine</td>
<td>300 ng / ml</td>
</tr>
<tr>
<td>Marijuana</td>
<td>50 ng / ml</td>
</tr>
<tr>
<td>Opiates</td>
<td>2000 ng / ml</td>
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<tr>
<td>Phencyclidine</td>
<td>25 ng / ml</td>
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</tbody>
</table>

All test results will be reviewed by a Saint Francis Hospital physician who is certified as a Medical Review Officer to evaluate drug test results. If the laboratory indicates that the specimen tests positive for one of the 5 drugs listed above, the Medical Review Officer will call you to discuss the test results.

One of the following results will be reported to the Human Resources Representative at your company:

**POSITIVE, NEGATIVE, or TEST NOT PERFORMED**

We will be happy to answer any questions you may have. Thank you for your cooperation.

James E. Mazo III, MD

**Medical Director of Occupational Health**
**OCCUPATIONAL HEALTH**

**WORK, ENVIRONMENT AND HEALTH QUESTIONNAIRE**

Today’s Date: __________________________  Date of Birth: __________________________

Name: ___________________________________________ Social Security #______/______/______

Address: ______________________________________________________________________

City: ___________________________________________ State: __________ Zip Code: _______________

Home Phone #: ______________________________ Cell Phone #:________________________________

**IMMUNIZATION HISTORY**

You must provide a written record signed by your physician with dates for the following vaccinations, illnesses or bloodwork/tests at the time of your appointment otherwise you will be tested for immunity to these diseases. You cannot be cleared until complete information is received.

Measles (rubeola): Date of illness ____________ Date of immunization: #1 __________ #2 ___________

Date of lab test: ________________ Result: ________________

Rubella (German measles): Date of illness ______________

Date of immunization: #1 _____________ #2 _____________

Date of lab test: ________________ Result: _____________

Please provide the dates for the following where applicable:

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Lab titer result</th>
<th>Illness</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Diphtheria/Tetanus</td>
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<tr>
<td>Hepatitis B</td>
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<tr>
<td>TB skin test/BCG</td>
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<tr>
<td>Polio</td>
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<tr>
<td>Rabies</td>
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</tbody>
</table>

NOTES:
**OCCUPATIONAL HISTORY**

List every place where you have been employed for more than six (6) months back to your first job, starting with your current or most recent job.

<table>
<thead>
<tr>
<th>Start Mo/Yr</th>
<th>End Mo/Yr</th>
<th>Employer Type of Business</th>
<th>Job Title</th>
<th>Job Duties</th>
<th>Exposures</th>
</tr>
</thead>
<tbody>
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</table>

Have you ever worn a respirator at work?  Yes _____  No _____
Were you able to perform your job with a respirator on?  Yes _____  No _____
Do you wear contact lenses?  Yes _____  No _____

Hobbies:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Previous work injuries: Y / N – If yes please explain:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
SMOKING AND ALCOHOL USE

Have you ever smoked cigarettes regularly? Yes _____ No _____
If yes, do you still smoke? Yes _____ No _____
When did you quit smoking? (Date) _____________________
How many years have you smoked, or if you no longer smoke, how many years did you smoke? _____ yrs.
On the average, how many packs per day do you smoke, or if you no longer smoke, how many did you smoke? ___________ packs per day.
Have you ever smoked a pipe or cigars regularly? Yes _____ No _____
Have you ever been a regular consumer of beer or other alcohol? Yes _____ No _____

FAMILY PHYSICIAN

Name: _________________________________________________________________________________
Address: ________________________________________________________________________________
Telephone Number ____________________________ Date last seen by a physician: ___________________
Are any other physicians currently treating you? Yes ____ No ____
If yes, please write their name, address and telephone number:
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
**MEDICAL HISTORY**

Have you ever been in the hospital?  Yes _____  No _____

If yes, when, where, and why?

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Current Medications: ________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Allergies to medications and other substances: ___________________________________________
_______________________________________________________________________________________

Do you have or have you ever had any of the following:

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Date of Onset</th>
<th>If yes, please detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARTHRITIS, RHUMATIC FEVER</td>
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<tr>
<td>BLOODDISORDER, INCLUDING ANEMIA</td>
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<tr>
<td>LIVER DISEASE, INCLUDING HEPATITIS</td>
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<tr>
<td>SKIN CONDITION</td>
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<tr>
<td>MISCARRIAGE (SELF OR PARTNER)</td>
<td></td>
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<tr>
<td>INFERTILITY, CHILD WITH BIRTH DEFECT</td>
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<tr>
<td>TUBERCULOSIS</td>
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<tr>
<td>ULCERS, OTHER STOMACH OR BOWEL DISEASE</td>
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<tr>
<td>GALL BLADDER DISEASE</td>
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<tr>
<td>DISORDER OF BONES OR MUSCLES</td>
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<tr>
<td>FRACTURES</td>
<td></td>
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<tr>
<td>THYROID PROBLEMS</td>
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<tr>
<td>DIABETES</td>
<td></td>
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<tr>
<td>KIDNEY DISEASE</td>
<td></td>
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<tr>
<td>PROBLEMS W/PERIPHERAL NERVOUS SYSTEM</td>
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<tr>
<td>(WEAKNESS, NUMBNESS)</td>
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<tr>
<td>RUPTURE OF EARDRUM, HEARING LOSS</td>
<td></td>
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<tr>
<td>CANCER OR TUMOR (TYPE)</td>
<td></td>
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<tr>
<td>EPILEPSY (SEIZURES)</td>
<td></td>
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<tr>
<td>BACK INJURY, PAIN OR TROUBLE</td>
<td></td>
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<tr>
<td>MENTAL ILLNESS OR BREAKDOWN</td>
<td></td>
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<tr>
<td>LUNG CONDITIONS (BRONCHITIS, EMPHYSEMA, PNEUMONIA, ASTHMA, BLOOD CLOT IN LUNGS)</td>
<td></td>
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<td></td>
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<tr>
<td>INJURIES TO OTHER BODY PARTS</td>
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<tr>
<td>HEART DISEASE, INCLUDING HYPERTENSION</td>
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<tr>
<td>OTHER CONDITIONS</td>
<td></td>
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</tr>
<tr>
<td>IMMUNIZATIONS</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>DATE OF LAST EYE EXAM</td>
<td></td>
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</table>
N95 TUBERCULOSIS RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

This questionnaire is required by OSHA to determine if you have a medical condition that may affect your ability to safely wear a respirator. The information on this form will be kept with your confidential Occupational Health records additional information or medical examination/testing may be requested. Please forward your completed questionnaire in a confidential envelope to Occupational Health and Health Promotion. You will need to complete required tuberculosis respirator education and respirator fit testing prior to using a respirator.

Name ___________________________ Social Security Number ________________________
Date of Birth _____ / _____ / _______ Home Address __________________________________
Telephone (home) ______________________ Telephone (work) ________________________
Job Title __________________________ Employer ________________________________________

How often will you need to wear this respirator? ____________________________

Have you worn a respirator before? _________ Did you have any problems with it? _________

Describe ____________________________

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING? IF YES DESCRIBE ON BACK → NO → YES →

1. Chest pain, tightness, shortness of breath during exertion: walking, running, climbing stairs? [ ] [ ] →
2. Angina or coronary artery disease (Hardening of the arteries) [ ] [ ] →
3. A heart attack [ ] [ ] →
4. Coronary artery bypass surgery [ ] [ ] →
5. High blood pressure [ ] [ ] →
6. Current asthma or wheezing [ ] [ ] →
   (If you use an inhaler, bring it with you to fit testing.)
7. Emphysema or other lung disorders [ ] [ ] →
8. Frequent cough [ ] [ ] →
9. Phlegm associated with cough [ ] [ ] →
10. Claustrophobia/fear of confined spaces [ ] [ ] →
11. Nasal disorder, abnormal sense of smell, or sinus congestion [ ] [ ] →
12. Skin condition [ ] [ ] →
13. Environmental Allergies including pollen, dander [ ] [ ] →
14. Allergy to latex [ ] [ ] →
15. Seizure disorder [ ] [ ] →
16. Diabetes/sugar [ ] [ ] →
17. Anemia/low blood count [ ] [ ] →
18. Has a physician told you that you have an abnormal breathing test? [ ] [ ] →
19. Any condition not already mentioned that would make it difficult for you to use a respirator? [ ] [ ] →
20. Do you wear glasses [ ] [ ] →
21. Do you wear contacts? [ ] [ ] →
22. Do you wear dentures [ ] [ ] →
23. Do you grow a beard? [ ] [ ] →
24. Have you ever smoked? [ ] [ ] →
25. Do you smoke now [ ] [ ] →
26. Do you take medication on a regular basis? [ ] [ ] →

REMEMBER TO DESCRIBE YES RESPONSES ON THE BACK OF THIS FORM →

Patient Signature ______________________ Date: __________________________

Occupational Health Staff Only: Medical Examination Indicated __________________________ Medical Examination Not Indicated __________________________
TB SKIN TEST (PPD) QUESTIONNAIRE

You will be given a skin test for Tuberculosis. Circle one answer below.

1) Have you had a TB skin test in the past?
   YES  NO

2) If yes, were you told it was “positive” or was there any redness or swelling?
   YES  NO

3) Have you ever had a BCG vaccine (given in countries outside of the U.S.)?
   YES  NO

4) Have you or any of your family members been exposed to active TB?
   YES  NO

5) Have you had a viral illness or received any vaccinations in the past 4 weeks?
   YES  NO

6) Do you currently take cancer medicine or steroids?
   YES  NO

* IF YOU ARE PREGNANT OR NURSING, YOU WILL NEED PERMISSION FROM YOUR PHYSICIAN PRIOR TO TAKING THIS TEST*

Print name: _________________________________________ Date: __________________________

SS#:________________________________ Date of Birth: __________________________________

FOR OFFICE USE ONLY:

Time Given:  DATE:
ARM:  RIGHT  LEFT  PRACTITIONER:
Manufacturer/LOT#:  EXPIRATION DATE:

RESULTS.  Date Read:_____________  Time Read: ______________
Negative_____ Positive _________  Erythema _______ x_______ Induration _______ x_______
Read by: _____________________________________________
DIRECTIONS TO THE DEPARTMENT OF OCCUPATIONAL HEALTH
AT SAINT FRANCIS HOSPITAL

114 Woodland Street
Hartford, CT 06105

Telephone: (860) 714-4270   Fax: (860) 714-8068

From I-84 Westbound: Take Exit 48, Asylum Street. From exit ramp, right onto Garden Street. At second traffic light, left onto Collins Street for six blocks. Left onto Woodland Street to entrance.

From I-84 Eastbound: Take Exit 46, Sisson Avenue (a left exit). From exit ramp, turn right onto Sisson Avenue for four blocks. Right onto Farmington Avenue for three blocks. Left onto Woodland Street for three blocks to entrance.

From I-91 Northbound: Take Exit 32-A to I-84 Westbound. West on I-84 to Exit 48. Asylum Street. From exit ramp, turn right onto Garden Street. At second traffic light, left onto Collins Street for six blocks. Left onto Woodland Street to entrance.

From I-91 Southbound: Take Exit 32-A to I-84 Westbound. West on I-84 to Exit 48, Asylum Street. From Exit ramp, turn right onto Garden Street. At second traffic light, left onto Collins Street for six blocks. Left onto Woodland Street to entrance.

After entering Collins Parking garage and parking, go to the garage 2nd floor entrance. There are elevators or stairs available on each level of the parking garage to the 2nd floor. PLEASE MAKE SURE TO BRING PARKING TICKET WITH YOU SO WE CAN VALIDATE AT NO CHARGE TO YOU.

If you arrive at the 2nd floor via the elevator, turn right and exit through the doors to the parking garage 2nd level and turn right. The entrance to the Gengras Medical Office Building will be straight ahead. At the end of the corridor, turn right and then take your first left. There will be a bank of elevators on your left. You will be going up to the fourth floor. Take a right off the elevators and go straight. Suite 4320 is straight ahead.

If you lose your way, there are courtesy phones in the hallways. Dial 44270 for the reception desk within our department.