



Appendix XIII

Employee Screening, Evaluation, Tracking and Decision-Making Tools

Communicable Disease Pre-Placement Medical Evaluation

If you would like to review this questionnaire with someone, bring the completed form to Occupational Health Services. Otherwise send the completed form in a confidential envelope: Dr. Robert Kosnik, Occupational Health Services, 2330 Post Street, Box 1661, San Francisco, CA 94143

For additional questions about this form, call 415-885-7580. Medical Information is strictly confidential.

Form with fields: Name (Last, First, MI), Employee #, Contact Telephone number (Home, Work, Mobile), Age, Sex, Today's Date, Job Location (city, state), Job Title, Department.

Do you have now, had in the past, or never had any of the following conditions? (Check only one box.)

- 1. Seizures (fits or epilepsy)
2. Diabetes (sugar disease)
3. Allergic reactions that interfere with your breathing
4. Hepatitis B
5. Asthma
6. HIV positive status
7. Immunosuppressive Disorder
8. Pregnancy, currently

Do you currently take prescription medications for any of the following problems? (Check only one box.)

- 9. Breathing or lung problems (including asthma)
10. Heart trouble
11. Blood pressure
12. Seizures (fits)
13. Medication for any other condition (please describe condition briefly below):

Do you currently have any of the following symptoms? (Check only one box.)

- 14. Eye irritation
15. Skin allergies or rashes
16. Anxiety
17. General weakness or fatigue
18. Any other problem that interfered with your use of a respirator, a mask, goggles or other personal protective equipment?

If you checked "NOW" or "YES" to any of the above questions (1-18), please briefly explain your answers below:

Signature: _____ Date: ___/___/_____

UCSF Occupational Health Services (OHS)
2330 Post Street, Box 1661
San Francisco, CA 94143
Phone: 415-885-7580; Fax: 415- 771-4472
Business Hours: M-F 7:30 a.m.-3:30 p.m.

Guidelines for “Yes Desk” screening-STAFF only

I. Employee Details

Please ensure that all areas are complete.

II. Exposure Risk

➤ Hospitals

If “yes”, to working at any of the hospitals in question (Hospital’s at a level 1 and up), please refer them to OHS (Occupational Health Services) at 2330 Post St. screening desk for further follow-up.

If “yes”, to other hospital that we do not have listed, please keep the tracking form for the command post. There is no need to send them to OHS.

➤ Multi-site approval

If the answer is “yes” to multi-site approval then allow them to continue working-a list from the command post should be formulated daily for the RN at the doors for screening.

If the answer is “no” then a multi-site exemption form needs to be completed by their direct manager.

➤ Contact of cases

If “yes” to contact with a suspect or probable case, outside of UCSF Medical Center without protection, refer to OHS screening desk for an assessment.

➤ Visitors of endemic region

If “yes”, to visiting endemic region in the last 10 days, please send home. 10 days quarantine will start from the day after they leave the area in question. Call OHS at 415-885-7580 and report the individual’s name and telephone number. OHS will follow up. They will not be allowed entry to the building and should follow instructions for home isolation.

➤ Quarantine or home isolation

If “yes”, to having been under quarantine or home isolation, clarify the dates of start and stop. If the date has expired then they are cleared to return to work. If the quarantine date is still active, send home, report name and telephone number. OHS will follow up.

OHS will collect tracking forms for those on home isolation or quarantine regularly.

III. Symptoms

➤ **Fever:** over **38 degrees** please send staff directly to ER for assessment.

➤ **Myalgia, Headache, Malaise, Cough, SOB:**

If 2 or more symptoms, refer to OHS screening desk. If outside OHS hours, send to ER for further assessment.

If **1** symptom, please clear to proceed to work unless the staff has an issue regarding their ability to work. If there is an issue please refer to OHS during business hours. Outside of OHS business hours please contact the Nursing Supervisor.

Healthcare Worker Communicable Disease Tracking Form

Tracking Code: _____
Employee Home Department _____
Circle Category: Home Quarantine/Home-Work Quarantine/Self Monitor/Other: _____
Start Date for Home Quarantine/Home-Work Quarantine/Self Monitor/Other: _____
Return to Work: _____

EMPLOYEE DETAILS

Name and Employee ID:	Position:
Dept.:	Contact Telephone#: ()

EXPOSURE RISK

Contact with: (check)

Location of Exposure:

Parnassus	Date _____	Worker <input type="checkbox"/>	Visitor <input type="checkbox"/>	Patient <input type="checkbox"/>
Mt. Zion	Date _____	Worker <input type="checkbox"/>	Visitor <input type="checkbox"/>	Patient <input type="checkbox"/>
SFGH	Date _____	Worker <input type="checkbox"/>	Visitor <input type="checkbox"/>	Patient <input type="checkbox"/>
VA	Date _____	Worker <input type="checkbox"/>	Visitor <input type="checkbox"/>	Patient <input type="checkbox"/>
Outpatient	Date _____	Worker <input type="checkbox"/>	Visitor <input type="checkbox"/>	Patient <input type="checkbox"/>
Other: _____	Date _____	Worker <input type="checkbox"/>	Visitor <input type="checkbox"/>	Patient <input type="checkbox"/>
_____	Date _____	Worker <input type="checkbox"/>	Visitor <input type="checkbox"/>	Patient <input type="checkbox"/>

- Contact with known or suspect case: _____
- Contact with quarantined or isolated staff/friend/family: _____
If yes, do they have any symptoms? _____
- Recent history of travel to epidemic region? Have you quarantined yourself for 10 days?
Yes dates of quarantine _____
No refer home, inform OHS of dates.

SIGNS AND SYMPTOMS: (check)

Are there any other underlying diagnoses that may be contributing to your symptoms (i.e. asthma, allergies)?

Fever (over 38)-direct to ER for an assessment	<input type="checkbox"/>	SOB	<input type="checkbox"/>	GI Symptoms (n/v/d)	<input type="checkbox"/>
Malaise	<input type="checkbox"/>	Cough	<input type="checkbox"/>		
Myalgia	<input type="checkbox"/>				
Other	<input type="checkbox"/>				

ACTION PLAN

Cleared to work: YES Return to duties
NO Send home: OHS will f/u with phone call

Medical Attention: Parnassus Emergency Primary MD Other _____

Follow-Up _____

Signature: _____ Date: _____

Entered in Database:

HCW COMMUNICABLE DISEASE EXPOSURE RUBRIC
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	No Known Exposure				Exposure Within the Past 10 Days			
	No Contact		Contact of Contact ¹		Contact ²			Case ³
					Unprotected ⁴ / Breach of Protection ⁷		Protected ⁵	
No Symptoms	• Return to Work		• Return to Work		<ul style="list-style-type: none"> • Send Home • Quarantine for 10 days • Kit with PPE, if applicable • Maintain contact with OHS • OHS notify Public Health 		• Return to Work	• Under physician care
Symptoms	Fever >38C	Send to ER Notify OHS	Fever > 38C	Send to ER Notify OHS	<ul style="list-style-type: none"> • Refer to ER for evaluation as a case If employee is a contact , not a case: <ul style="list-style-type: none"> • quarantine for ___days (specify) • Kit with 2 masks • Maintain contact with OHS • OHS call Public Health 	Fever > 38C	Send to ER Notify OHS	• Under physician care
	Malaise Myalgia Headache Cough Shortness of breath	One symptom: return to work Two or more symptoms: consult OHS/ER	Malaise Myalgia Headache Cough Shortness of breath	One symptom: return to work For two or more symptoms consult OHS/ER		Malaise Myalgia Headache Cough Shortness of breath	One symptom: return to work. Monitor temperature 2X per day for ___days (specify). Two or more symptoms: consult OHS/ER	

HCW COMMUNICABLE DISEASE EXPOSURE RUBRIC
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1. A Contact of Contact is someone who came into contact with a quarantined individual, (e.g., spouse of a quarantined contact from an affected health care institution).
2. A Contact is someone who came into contact with a case. A Contact may include someone who has:
 - **A)** Traveled to an affected area; **B)** Worked at an institution designated by Public Health to care for confirmed, suspect, or probable case patients; **C)** Experiences breach of Infection Control Precautions for “suspect”, “possible”, and “probable” cases under investigation.For individuals who visited, worked at, or were a patient in an affected or designated institution, please obtain the following:
 - **A)** Date of contact(s), **B)** Location(s) of contact(s), **C)** Contact name(s), if possible.
3. A Case is someone who meets the case definition.
4. An Unprotected Contact is someone who came into contact with a confirmed, suspect or probable case less than 2 days prior to the onset of symptoms in the case (e.g., contact on Monday for a case whose symptoms emerged on Wednesday).
5. A Protected Contact is someone who came into contact with “suspect”, “possible”, “probable”, or “confirmed” case who was wearing proper protective equipment as determined by HEIC.
6. Off work for 2 to 10 days past the end of the symptoms, maintain usual contact with manager, call the OHS at 885-7580, and follow the usual return-to-work guidelines.
7. OHS **MUST BE NOTIFIED** of ALL staff cases of breach in infection control measures, and ALL staff with a fever over 38C.

RESPIRATORY VIRAL ILLNESS (including Influenza)
UCSF STAY AT HOME - RETURN TO WORK GUIDELINES FOR STAFF⁽¹⁾

Symptoms	Stay At Home	Return to Work
FEVER <ul style="list-style-type: none"> Fever (T38C or 100.4F) 	T > 38C or 100.4F	<ul style="list-style-type: none"> No fever for 24 hours⁽²⁾
RESPIRATORY SYMPTOMS WITHOUT FEVER <ul style="list-style-type: none"> Cough Sore throat Nasal Congestion / Runny Nose Myalgia (body aches) 	One or more symptoms on high risk units ⁽³⁾ Two or more symptoms on all other units ⁽⁴⁾	<ul style="list-style-type: none"> 24 hours after onset of symptoms AND <ul style="list-style-type: none"> No fever⁽²⁾ AND <ul style="list-style-type: none"> Symptoms have significantly improved
RESPIRATORY SYMPTOMS WITH FEVER (presumed Influenza) <ul style="list-style-type: none"> Fever (T38C or 100.4F) Cough Sore throat Nasal Congestion / Runny Nose Myalgia (body aches) 	T > 38C or 100.4F and at least one symptom	<ul style="list-style-type: none"> At least 5⁽⁵⁾ days after onset of symptoms AND <ul style="list-style-type: none"> No fever for 24 hours⁽²⁾ AND <ul style="list-style-type: none"> Symptoms have significantly improved

⁽¹⁾ Staff includes all employees, faculty, temporary workers, trainees, volunteers, students, and vendors, regardless of employer. This includes staff who provide services to or work in UCSF Medical Center patient care or clinical areas.

⁽²⁾ Assumes the individual has not taken fever-reducing medication (e.g. Tylenol, Motrin).

⁽³⁾ High risk units include adult and pediatric hematology / oncology / BMT services (7 Long, 11 Long, 14L annex, Hematology / Oncology Outpatient Clinic, Infusion outpatient clinic, and Pediatric Treatment Center.) **For high-risk units, there is a zero tolerance policy of working while ill.**

⁽⁴⁾ If you have received the seasonal influenza and H1N1 vaccine and work on units other than high-risk units, you may work with minimal symptoms if you adhere to excellent hand hygiene and wear a mask when performing direct patient care activities.

⁽⁵⁾ For the purposes of counting the days, the onset of symptoms happens on Day 0. Day 1 begins the next calendar day. e.g. Symptoms begin on Sunday; Sunday is day zero; Monday is day one; and Friday is day five. You can return to work **if well**.

Questions about the process should be directed to Occupational Health Services at 885.7580 or OHS@ucsfmedctr.org.