

Section A – Hospital Hepatitis B Vaccination

Data Collection Form

Date: Month _____ Year _____

Hospital Code Number: _____

1. Does your hospital have a documented policy on administration of Hepatitis B vaccine to health care workers? *(please tick)*

Yes No
(If 'No', proceed to question 3)

2. Does this policy adhere to the recommendations as outlined (page 5–13)? *(please tick)*

Yes No

3. What number of non-casual staff are employed at your hospital?

Occupational Group	Number
Medical staff	
Nursing staff	
Allied Health staff	
Other staff who have clinical contact	
Laboratory staff	
Total	

Section B – Hospital Hepatitis B Vaccination Summary

Data Collection Form

Date: Month _____ Year _____

Hospital Code Number: _____

For ALL non-casual staff:

Primary course of Hepatitis B vaccination:

<i>Occupational Group</i>	Number of staff			Total
	Yes	No	Unsure	
Medical staff				
Nursing staff				
Allied Health staff				
Other staff who have direct or indirect clinical contact				
Laboratory staff				
Total				

Section C – Health Care Worker Hepatitis B Vaccination Data Collection Form

Name: _____ **Date:** ____ / ____ / _____

Your hospital has elected to participate in a voluntary VICNISS project to determine the current status of Health Care Workers susceptible to hepatitis B. **This data collection form is confidential and will not be sent to the VICNISS Coordinating Centre.** The VICNISS Coordinating Centre (funded by the Department of Human Services) will be responsible for data analysis and reporting de-identified aggregate hospital data.

The data collection form, once completed is to be forwarded to: _____

Could you please answer the following questions as specified: *(please tick)*

1. Please tick your Occupational group:

<i>Occupational Group</i>	<i>Tick</i>
Medical staff	
Nursing staff	
Allied Health staff	
Other	
Clinical contact staff member (Example, Ward clerk, Environmental Services staff)	
Laboratory staff	
Non-clinical contact staff member (Example, Gardener and Clinical staff)	

2. Could you please answer the following two questions:

a. Have you had a primary course (3 doses) of Hepatitis B vaccination? *(Please tick)*

Yes No Unsure

b. If **'Yes'**, after the third dose at about 4 weeks, did you have a blood test to check your anti HB level (or that the vaccinations were working)? *(Please tick)*

Yes No Unsure

Comments:

If you require further information please contact: _____

Thank you for your participation