Insert name of transport operator

Rail Safety Worker Health Assessment
Category 1 and 2
Worker Notification and Health Questionnaire

CONFIDENTIAL:

FOR PRIVACY REASONS THE COMPLETED FORM SHOULD BE RETAINED BY THE AUTHORISED HEALTH PROFESSIONAL AND NOT RETURNED TO THE RAIL TRANSPORT OPERATOR

Instructions for the worker/applicant

- You are required to attend a health assessment as a condition of your employment, to assess your fitness for rail safety work.
- The health assessment must be completed by _____ *(date)* to ensure that you are able to carry out normal duties.
- Complete the enclosed questionnaire **before attending the appointment** and provide it to the examining doctor. **The last page of the questionnaire must be signed by you in the presence of the examining doctor.**
- Please take to the appointment:
  - glasses, hearing aid or any other aids required for conduct of your work.
  - all medication that you are currently taking or a list of such medications.
  - photo identification.
- If you are a **Category 1 Safety Critical Worker** you will be required to have a blood test as part of your assessment. To get a true reading of your blood sugar and cholesterol (total and HDL) you must not eat for a minimum of 8 hours (and no longer than 14 hours) before your blood test. You may drink water but should not take sweetened drinks. This appointment/test should take place at least 48 hours before the appointment with the doctor so that he/she has the results.

What happens if the examining doctor suspects there is a health problem?

If the examining doctor finds or suspects something is wrong with your health that you did not know about, they will ask your permission to inform your own doctor. The examining doctor will not treat any medical condition but will give you a letter to take to your own doctor.

If the doctor finds that you do not meet all relevant medical criteria, your supervisor at the rail transport operator will discuss with you the appropriate action to be taken. This may include:

- modification of the duties that you undertake for the rail transport operator; and/or
- scheduling of a further review, tests or specialist referral.

Disclosure of health information – please read carefully and sign to indicate you understand how health information is reported, stored and accessed.

All your detailed medical papers including your questionnaire responses, test results and the complete record of clinical findings are kept confidentially, and are not available to your managers. The examining doctor sends only the completed report form directly to the rail transport operator indicating your fitness or otherwise for duty.

If the rail transport operator uses the services of a Chief Medical Officer (CMO), the CMO may access a copy of your health record to aid in the management of your health in relation to your work or for audit purposes or to compile statistics. The CMO must maintain the confidentiality of these records and ensure that your personal information is not made available to, or discussed with, any other person within the organisation.

Other than the above, your personal information will not be disclosed to any other person or organisation without your written permission, except:

- when the rail transport operator appoints a health professional to conduct an audit of the system for the health assessment of rail safety workers, then the appointed health professional will have access to the information for the purpose of undertaking the audit; and
- where required by law.

You have the right to access your health records including those held by the Authorised Health Professional and the reports held by the rail transport operator.

Worker's Declaration

I, _____ *(print name)* certify that I have read and understood the above statement concerning the health information provided in this document.

Signature _____ Date _____

PART A – Rail transport operator to complete

Date of request

Worker / Applicant details

Family name

First names

Employee no.

Date of birth

Risk Category ☐ Category 1 ☐ Category 2

Health assessment appointment details

Doctor /Practice

Address

Phone

Appointment Date

Time

PART B – Health Questionnaire – Worker / Applicant to complete

This questionnaire must be completed in order to help assess your fitness for rail safety duties. Please answer the questions by ticking the appropriate box or circling the appropriate response. If you are not sure, leave the question blank and ask the examining health professional what it means. The health professional will ask you more questions during the assessment.

1. Are you currently attending a health professional for any illness or injury?

☐ No

☐ Yes *Briefly describe including any medical treatment or medication (prescribed or otherwise) that you are receiving*

2. Have you ever had, or been told by a doctor that you had any of the following?

	Yes	No		Yes	No
High blood pressure	☐	☐	Dizziness, vertigo, problems with balance	☐	☐
Heart disease	☐	☐	Double vision, difficulty seeing, or difficulty adapting to changing light conditions	☐	☐
Chest pain, angina	☐	☐			
Any condition requiring heart surgery	☐	☐	Colour blindness	☐	☐
Abnormal shortness of breath or chest disease	☐	☐	Memory loss or difficulty with attention or concentration	☐	☐
Palpitations / irregular heartbeat	☐	☐	Diabetes	☐	☐
Head injury, spinal injury	☐	☐	Neck, back or limb disorders	☐	☐
Seizures, fits, convulsions, epilepsy	☐	☐	Hearing loss or deafness or had an ear operation or use a hearing aid?	☐	☐
Blackouts or fainting	☐	☐			
Stroke	☐	☐	A psychiatric illness or nervous disorder?	☐	☐

3. Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?

☐ No ☐ Yes *(briefly describe below)*

PART B (continued)

4. The following questions relate to your intake of alcohol. Please circle the answer that is correct for you:

		(0)	(1)	(2)	(3)	(4)	*Official use only*
4.1	How often do you have a drink containing alcohol?	Never *(Go to Q5)*	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
4.2	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 4	5 to 6	7 to 9	10 or more	
4.3	How often do you have six or more drinks on one occasion?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
4.4	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
4.5	How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
4.6	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
4.7	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
4.8	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
4.9	Have you or someone else been injured as a result of your drinking?	No		Yes but not in the last year		Yes during the last year	
4.10	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes but not in the last year		Yes during the last year	
						TOTAL	

5. The following questions are about your sleeping patterns:

5.1 Have you ever had, or been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy? ☐Yes ☐ No

5.2 Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep? ☐Yes ☐ No

Please use the following scale (Epworth Sleepiness Scale) to choose the most appropriate description for each situation. The questions refer to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

5.3 How likely are you to doze off or fall asleep (rather than just feeling tired) in the following situations:	Would never doze off (0)	Slight chance of dozing (1)	Moderate chance of dozing (2)	High chance of dozing (3)	***Official use only***
• Sitting and reading	☐	☐	☐	☐	
• Watching TV	☐	☐	☐	☐	
• Sitting, inactive in a public place (e.g. a theatre or meeting)	☐	☐	☐	☐	
• As a passenger in a car for an hour without a break	☐	☐	☐	☐	
• Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐	
• Sitting and talking to someone	☐	☐	☐	☐	
• Sitting quietly after a lunch without alcohol	☐	☐	☐	☐	
• In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐	
				TOTAL	

PART B (continued)

6. Do you smoke or have you ever been a smoker?

☐ No

☐ Ex-smoker *Quit date*

☐ Yes *Number of cigarettes per day*

7. Do you use illicit drugs?

☐ No

☐ Yes *(describe)*

8. The following questions relate to how you are feeling. Please tick the answer that is correct for you.

In the <u>past 4 weeks</u>, about how often did you:	All of the time (5)	Most of the time (4)	Some of the time (3)	A little of the time (2)	None of the time (1)	***Official use only***
• Feel tired out for no good reason?	☐	☐	☐	☐	☐	
• Feel nervous?	☐	☐	☐	☐	☐	
• Feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐	
• Feel hopeless?	☐	☐	☐	☐	☐	
• Feel restless or fidgety?	☐	☐	☐	☐	☐	
• Feel so restless you could not sit still?	☐	☐	☐	☐	☐	
• Feel depressed?	☐	☐	☐	☐	☐	
• Feel that everything was an effort?	☐	☐	☐	☐	☐	
• Feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐	
• Feel worthless?	☐	☐	☐	☐	☐	
				TOTAL		

PART C – For existing employees only

9. Have you experienced difficulty completing any tasks required for your work (e.g. walking on ballast, hearing train instructions)?

☐ No

☐ Yes *(briefly describe)*

10. Have you been involved in any accidents or near misses at work in the period since your last assessment?

☐ No

☐ Yes *(briefly describe)*

PART D – Worker's declaration

(To be completed by the worker in the presence of the health professional after completing the questionnaire)

I, *(print name)*

certify that to the best of my knowledge the information provided by me is true and correct.

Signature of worker

Signature of doctor

Date

Clinician notes