

Name of rail 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 to the worker / applicant

- You are required to attend a health assessment as part 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; and
 - 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 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 you should not have sweetened drinks or juice. 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 actions 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 of 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 confidential, 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.

Doctor comments

1. Are you currently attending a health professional for any illness or injury? No Yes

2. Do you suffer from or have you ever suffered from: Doctor comments

High blood pressure No Yes

Heart disease No Yes

Chest pain, angina No Yes

Any condition requiring heart surgery No Yes

Abnormal shortness of breath or chest disease No Yes

Palpitations / irregular heartbeat No Yes

Head injury, spinal injury No Yes

Seizures, fits, convulsions, epilepsy No Yes

Blackouts or fainting No Yes

Stroke No Yes

Dizziness, vertigo, problems with balance No Yes

Double vision, difficulty seeing, or difficulty adapting to changing light conditions No Yes

Colour blindness No Yes

Memory loss or difficulty with attention or concentration No Yes

Diabetes No Yes

PART B (continued)

2. Do you suffer from or have you ever suffered from:	Doctor comments
Neck, back or limb disorders	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hearing loss or deafness or had an ear operation or use a hearing aid	<input type="checkbox"/> No <input type="checkbox"/> Yes
A psychiatric illness or nervous disorder	<input type="checkbox"/> No <input type="checkbox"/> Yes

Doctor comments	
3. Have you ever had any other serious injury, illness, operation, or been in hospital for any reason? Please describe briefly below.	<input type="checkbox"/> No <input type="checkbox"/> Yes

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

	(0)	(1)	(2)	(3)	(4)
4.1 How often do you have a drink containing alcohol?	<input type="checkbox"/> Never (go to Q5)	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2 to 4 times per month	<input type="checkbox"/> 2 to 3 times per week	<input type="checkbox"/> 4 or more times per week
4.2 How many drinks containing alcohol do you have on a typical day when you are drinking?	<input type="checkbox"/> 1 or 2	<input type="checkbox"/> 3 to 5	<input type="checkbox"/> 5 to 6	<input type="checkbox"/> 7 to 9	<input type="checkbox"/> 10 or more
4.3 How often do you have six or more drinks on one occasion?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2 to 4 times per month	<input type="checkbox"/> 2 to 3 times per week	<input type="checkbox"/> 4 or more times per week
4.4 How often during the last year have you found that you were not able to stop drinking once you had started?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2 to 4 times per month	<input type="checkbox"/> 2 to 3 times per week	<input type="checkbox"/> 4 or more times per week
4.5 How often during the last year have you failed to do what was normally expected from you because of drinking?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2 to 4 times per month	<input type="checkbox"/> 2 to 3 times per week	<input type="checkbox"/> 4 or more times per 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?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2 to 4 times per month	<input type="checkbox"/> 2 to 3 times per week	<input type="checkbox"/> 4 or more times per week
4.7 How often during the last year have you had a feeling of guilt or remorse after drinking?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2 to 4 times per month	<input type="checkbox"/> 2 to 3 times per week	<input type="checkbox"/> 4 or more times per 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?	<input type="checkbox"/> Never	<input type="checkbox"/> Monthly or less	<input type="checkbox"/> 2 to 4 times per month	<input type="checkbox"/> 2 to 3 times per week	<input type="checkbox"/> 4 or more times per week
4.9 Have you or someone else been injured as a result of your drinking?	<input type="checkbox"/> No		<input type="checkbox"/> Yes, but not in the last year		<input type="checkbox"/> 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?	<input type="checkbox"/> No		<input type="checkbox"/> Yes, but not in the last year		<input type="checkbox"/> Yes, during the last year

Doctor comments

5. The following questions are about your sleeping patterns:		Doctor comments
5.1	Have you ever been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy? <input type="checkbox"/> No <input type="checkbox"/> Yes	
5.2	Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep? <input type="checkbox"/> No <input type="checkbox"/> Yes	

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)
	• Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	• Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	• Sitting inactive in a public place (e.g. a theatre or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	• As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	• Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	• Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	• Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	• In a car, while stopped for a few minutes in the traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor comments

6. Do you smoke or have you ever been a smoker?	
<input type="checkbox"/> No	
<input type="checkbox"/> Ex-smoker	Quit date:
<input type="checkbox"/> Yes	Number of cigarettes per day:

Doctor comments

7. Do you use illicit drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes
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Doctor comments

PART B (continued)

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:	None of the time (1)	A little of the time (2)	Some of the time (3)	Most of the time (4)	All of the time (5)
• Feel tired out for no good reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Feel nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Feel so nervous that nothing could calm you down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Feel hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Feel restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Feel so restless you could not sit still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Feel depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Feel that everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Feel so sad that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Feel worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Doctor comments

PART C – For existing employees only

Doctor comments	
9. Have you experienced difficulty completing any tasks required for your work (e.g. walking on ballasts, hearing train instructions)? If yes, please describe:	<input type="checkbox"/> No <input type="checkbox"/> Yes
10. Have you been involved in any accidents or near misses at work in the period since your last assessment? If yes, please describe:	<input type="checkbox"/> No <input type="checkbox"/> Yes

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: