HM1(T) Health surveillance and assessment form

Reason for assessment: Health Surveillance (HS) ☐ Fitness for work (FFW) ☐ Wellbeing ☐

Please complete up to (but not including) SECTION 15 - Test Results.

SECTION 1 PERSONAL DETAILS					
Organisation			Screen location		
Division			Line manager	Name	
Work location				Tel No	
SURNAME			FORENAME(S)		
Employee ID			Gender	MALE ☐	FEMALE ☐
Date of Birth			Job title		
Contact No.			Years in role		
Do you work	FULL TIME ☐ Hours/week: ..... PART TIME ☐		Do you work shifts?	YES ☐	NO ☐
			Do you work nights/on call?	YES ☐	NO ☐
Home address	....		GP name & address	....	
Post code			Post code		

Please indicate the type of work your current job involves.							
	Confined Spaces ☐		Safety critical work ☐		Noise exposure ☐		
	BA Working set ☐		Operating machinery ☐		Skin irritants ☐		
	BA Escape sets ☐		Work at heights ☐		Respiratory irritants ☐		
	Lone/Night work ☐		Driving (car/van/FLT) ☐		Bio-aerosols ☐		
	Cold storage ☐		Driving (LGV/PSV) ☐		Vibrating tools ☐		
	Food handling ☐				Whole body vibration ☐		

SECTION 2 EMPLOYMENT/EXPOSURE HISTORY

1. Previous occupations including dates	
2. Personal hobbies & interests	

SECTION 3 PAST MEDICAL HISTORY

Please answer all questions. If yes, please give further details in the space provided.

PART 1 – REQUIRED FOR ALL ASSESSMENTS	YES	NO	Details (continue below if needed)
1. Have you had any serious illnesses, operations or injuries?	☐	☐	
2. Do you have any concerns or medical conditions that you think may be related to work?	☐	☐	
3. Are you currently receiving or awaiting any medical treatment?	☐	☐	
4. Do you take any regular medication? If yes, please specify.	☐	☐	
5. Are you currently, or have you previously, smoked? If yes, you many did you smoke per day?:	☐ Current smoker ☐ Ex-smoker ☐ Non-smoker		..... per day
6. Do you drink alcohol? If yes, you many units per week?:	☐	☐	..... units per week
7. Are you allergic to:			
any medication?	☐	☐	
any substance within the workplace?	☐	☐	
household dust?	☐	☐	
tree or grass pollen?	☐	☐	
any household products?	☐	☐	
any foodstuffs?	☐	☐	
animal fur or feathers?	☐	☐	

PART 2 – REQUIRED FOR ALL FFW ASSESSMENTS	YES	NO	Details (continue below if needed)
8. Have you been absent from work because of illness in the last 12 months? If yes, please specify durations & reasons	☐	☐	
9. Do you have any restriction of movement in your back, or does any activity cause you back pain? If yes, please state when and how frequently. How long was your last episode?	☐	☐	
10. Do you have any restriction of movement in your neck, or does any activity cause you neck pain? If yes, please state when and how frequently.	☐	☐	
11. Do you have any problems with limbs or joints?	☐	☐	
12. Do you have any ear, nose or throat complaints?	☐	☐	
13. Do you have any hearing difficulties?	☐	☐	
14. Do you have asthma or any other chest condition?	☐	☐	
15. Do you suffer from any paralysis, blackouts, epilepsy or fits?	☐	☐	
16. Do you suffer from claustrophobia (a fear of enclosed or confined spaces)?	☐	☐	
17. Do you suffer from vertigo (a sensation that the environment is spinning around you, causing dizziness and loss of balance)?	☐	☐	
18. Do you suffer from any psychological or psychiatric condition, depression or anxiety, alcohol or drug dependency?	☐	☐	
19. Do you have any visual complaint including recurring headaches, blurred vision or eye discomfort?	☐	☐	
20. Do you have any form of neurological complaint, eg Multiple sclerosis, Parkinsons disease, brain injury?	☐	☐	
21. Do you have any sleep disorders (eg narcolepsy, sleep apnoea)?	☐	☐	
22. Do you have any form of heart or circulatory problems, eg angina or high blood pressure?	☐	☐	
23. Do you suffer from diabetes? If yes, please state type and whether controlled by diet, medication or insulin.	☐	☐	☐ Type 1 ☐ Type 2
24. Do you suffer from Raynaud's disease?	☐	☐	
25. Do you have any other health concerns not detailed above? If yes, please give details.	☐	☐	

FURTHER DETAILS

Question	Details

SECTION 4 SUPPLEMENTARY QUESTIONS: DRIVERS, NIGHT WORKERS, LONE WORKERS

Please answer all questions. If yes, please give further details in the space provided.

		YES	NO	Details (continue below if needed)
1.	Do you drive as part of your job (includes car, FLT, LGV, PVC, Plant) If yes, please specify type and give details below	☐	☐	☐ Group 1 (eg Car, Motorcycle, Light van, FLT) ☐ Group 2 (eg HGV, PSV, Plant)
2.	Do you work at night on a regular (frequent) basis?	☐	☐	
3.	Do you regularly work alone?	☐	☐	
	If you have answered NO to ALL the above questions you do not need to complete the rest of this section. Please go to next section.			
4.	Do you suffer or have you ever suffered from a condition which requires careful timing of treatment or medication?	☐	☐	
5.	Do you have persistent indigestion, gastric or duodenal ulcers?	☐	☐	
6.	Do you suffer from an intestinal/bowel complaint?	☐	☐	
7.	Do you have any visual impairment?	☐	☐	
8.	Do you have any medical condition that you feel could be adversely affected by night working?	☐	☐	
9.	Are you currently pregnant or breast feeding?	☐	☐	
10.	Have you ever been advised that you are unfit for work involving driving, night work or lone work?	☐	☐	

FURTHER DETAILS

Question	Details

SECTION 5 SUPPLEMENTARY QUESTIONS: WHOLE BODY VIBRATION

Please answer all questions. If yes, please give further details in the space provided.

		YES	NO	Details (continue below if needed)
1.	Does your current work involve exposure to whole body vibrations, such as driving over rough terrain?	☐	☐	
2.	Have you had any role in the past which has exposed you to whole body vibration? If yes: - What was the nature of the exposure? - How many years in total were you doing this role? - What percentage of the role involved whole body vibration exposure?	☐	☐	
	If you have answered NO to questions 1 and 2 you do not need to complete the rest of this section. Please go to next section.			
3.	Has there been any significant change in your duties/hours of work since your last assessment?	☐	☐	
4.	Are you exposed to any whole body vibration through any leisure or out of work activities? If yes, please give details.	☐	☐	
5.	**Females only:** Are you currently pregnant, or had a baby within the last six months?	☐	☐	
6.	Have you had any accidents or injury to your neck / back / shoulders within the last two years?	☐	☐	
7.	Have you suffered from back problems in the past? If yes: - Have you received any treatment or intervention? - Did you take medication to relieve the pain? - Did the pain keep you from your usual activities?	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	
8.	Are you currently experiencing any movement or activity which causes you pain in your back / neck / shoulders? If yes, please highlight the severity of pain experienced:	☐ None 1 2 3 4 5 6 7 8 9 10 Severe	☐	
9.	Are you currently taking medication to relieve the pain?	☐	☐	
10.	Have you had to seek medical advice regarding the current pain?	☐	☐	
11.	Has the current neck / back / shoulder pain resulted in time off work?	☐	☐	

FURTHER DETAILS

Question	Details

SECTION 6 SUPPLEMENTARY QUESTIONS: MANUAL HANDLING

Please answer all questions. If yes, please give further details in the space provided.

		YES	NO	Details (continue below if needed)
1.	Does your work involve lifting, repetitive movements or strenuous activity?	☐	☐	
	If you have answered NO to question 1 you do not need to complete the rest of this section. Please go to next section.			
2.	How long have you been doing your current role?			years
3.	Have you done similar physically demanding work in a previous role?	☐	☐	
4.	Do you have any restriction of movement or pain in your arms? If yes, please state when and how frequently.	☐	☐	
5.	Do you have any restriction of movement or pain in your wrists? If yes, please state when and how frequently.	☐	☐	
6.	Do you have any restriction of movement or pain in your hands? If yes, please state when and how frequently.	☐	☐	
7.	Is your grip strength restricted in your hands?	☐	☐	
8.	Do you have any restriction of movement or pain in your knees? If yes, please state when and how frequently.	☐	☐	
9.	Do your knees & hips prevent you from performing a full squat?	☐	☐	
10.	Have you ever taken time off work for any of the above? If yes, please state when frequency/duration of absence.	☐	☐	
11.	Have you consulted your GP or other health professional about any of the above?	☐	☐	
	If yes, has a diagnosis been made?	☐	☐	
	have you had any treatment for the condition?	☐	☐	
12.	Do you have any hernia or rupture?	☐	☐	
13.	Do any of the above conditions affect your ability to do your job? If yes, please give details.	☐	☐	

FURTHER DETAILS

Question	Details

SECTION 7 SUPPLEMENTARY QUESTIONS: FOOD HYGIENE

Please answer all questions. If yes, please give further details in the space provided.

		YES	NO	Details (continue below if needed)
1.	Do you work with food products?	☐	☐	
	If you have answered NO to question 1 you do not need to complete the rest of this section. Please go to next section.			
2.	Since your last assessment or start in this role:			
	- Have you suffered from flu-like symptoms?	☐	☐	
	- Have you suffered from sickness, diarrhoea, or any stomach complaint?	☐	☐	
	- Have you suffered from any infections to your nose, ears, eyes or skin?	☐	☐	
	- Have you had typhoid, paratyphoid, enteric fever or salmonella infections?	☐	☐	
3.	In the last 12 months have you had a productive cough, ie with spit, or had discharge from the eyes, ears or nose?	☐	☐	
4.	In the past 12 months have you had recurrent boils or septic fingers?	☐	☐	

FURTHER DETAILS

Question	Details

SECTION 8 SKIN & RESPIRATORY EXPOSURE

Please answer all questions. If yes, please give further details in the space provided.

		YES	NO	Details (continue below if needed)
1.	Do you work with any of the following? Isocyanates, Solvents, Flour, Grains, Epoxy resins, Solder fumes, Silica, Reactive dyes, Gluteraldehyde, Laboratory animals, Powders, Oils, Wood dusts, Degreasers, Bio-aerosols.	☐	☐	

If you have answered NO to this question you do not need to complete the Skin or Respiratory surveillance sections (where included). Please go to following section.

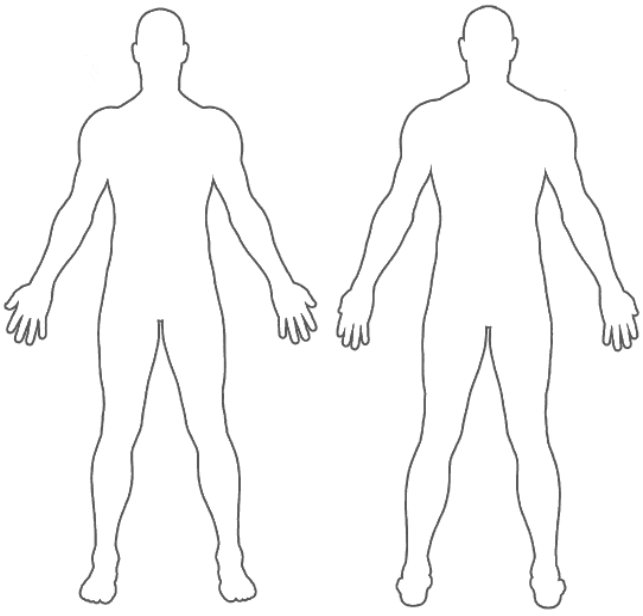
SECTION 9 SKIN SURVEILLANCE

Please answer all questions. If yes, please give further details in the space provided.

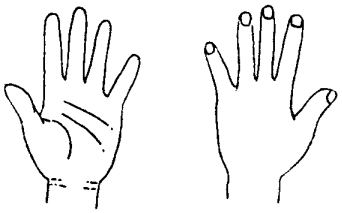
		YES	NO	Details (continue below if needed)
1.	Do you suffer from acne, eczema, psoriasis or warts?	☐	☐	
2.	Have you suffered from any dermatitis?	☐	☐	
3.	Since your last medical, or since your start in this post, have you suffered from soreness of your skin?	☐	☐	
4.	Have you developed any skin rashes?	☐	☐	
5.	Have you developed any cracks, blisters or excessive itchiness of the skin?	☐	☐	
6.	Have you had any other skin complaint?	☐	☐	

BODY MAP

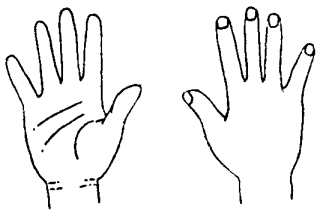
FRONT BACK



LEFT



RIGHT



FURTHER DETAILS

Question	Details

SECTION 10 RESPIRATORY SURVEILLANCE

Please answer all questions. If yes, please give further details in the space provided.

		YES	NO	Details (continue below if needed)
1.	Since your last medical, or since you started in this post, have you suffered from asthma?	☐	☐	
2.	Since your last medical, or since your start in this post, have you suffered from any other chest problem?	☐	☐	
3.	Have you had a night or early morning cough in the last 12 months?	☐	☐	
4.	Have you had any bouts of coughing in the winter?	☐	☐	
5.	Have you had any shortness of breath, or chest tightness?	☐	☐	
6.	Have you had any irritation or soreness of the throat?	☐	☐	
7.	Have you had red, sore, watery or itchy eyes?	☐	☐	
8.	Have you had a stuffy nose, nasal catarrh or bouts of sneezing?	☐	☐	
9.	Do the symptoms of any of the above improve at weekends or when you are not at work?	☐	☐	
10.	Are you currently suffering from a cold / chest condition?	☐	☐	
Please answer the following two questions ONLY if your work exposes you to bio-aerosols				
11.	Do you have any health problems which may supress your immune system? (Health problems include HIV/AIDS, splenectomy, leukaemia, lymphoma, congenital immune-deficiency)	☐	☐	
12.	Are you currently undergoing any treatment which may supress your immune system? (Treatments include chemotherapy, bone marrow transplant, steroids, disease-modifying anti-rheumatic drugs, transplant anti-rejection treatments)	☐	☐	

FURTHER DETAILS

Question	Details

SECTION 11 RESPIRATORY SURVEILLANCE
(Respirable Crystalline Silica only)

Please answer all questions. If yes, please give further details in the space provided.

		YES	NO	**Details** (continue below if needed)
1.	Have you undertaken RCS surveillance before?	☐	☐	
	If yes, has your job changed since your last surveillance?	☐	☐	
2.	Do you work in a high silica exposed job (eg tasks such as cutting, scabbling or grinding concrete, chasing, demolition or stonework)?	☐	☐	
	If yes, please provide details of the tasks involving silica below.			
	.....			
	.....			
3.	How long have you been doing this current job?	..... Years	..... Months	
4.	How long in total have you been working with Silica?	..... Years	..... Months	
5.	In which other areas of the organisation have you worked previously (if any)?	.....		
	.....			
6.	Do you currently use respiratory protective equipment (RPE)?	☐	☐	
	If yes, have you undergone face fit testing?	☐	☐	
7.	Do you undertake any hobbies with potential for exposure to silica?	☐	☐	
Since your last examination, or if this is your first, have you had any of the following?				
8.	An injury or operation affecting your chest?	☐	☐	
9.	Any chest illness that has kept you from your usual activities for as much as one week?	☐	☐	
10.	Do you bring up phlegm from your chest on most days (or nights) for as much as 3 months each year?	☐	☐	
11.	Does your chest ever become tight or breathing difficult?	☐	☐	
12.	Does your chest ever sound wheezy or whistle?	☐	☐	
13.	Do you usually get short of breath performing your usual activities?	☐	☐	
14.	Have you ever been diagnosed by a doctor to have any of the following? If yes, please give details.			
	- Asthma	☐	☐	
	- COPD	☐	☐	
	- Silicosis	☐	☐	
	- Pleurisy	☐	☐	
	- Emphysema	☐	☐	
	- Chronic bronchitis	☐	☐	
	- Tuberculosis	☐	☐	
	- Any other respiratory condition?	☐	☐	

SECTION 11 CONTINUED

	YES	NO	Details (continue below if needed)
15. Have you ever been diagnosed by a doctor to have kidney disease?	☐	☐	
16. Have you ever been diagnosed by a doctor to have arthritis or connective tissue problems?	☐	☐	
17. Have you ever been diagnosed by a doctor to have vasculitis?	☐	☐	
18. Have you had any recent unexplained weight loss?	☐	☐	
19. Have you any other concerns regarding your health?	☐	☐	

FURTHER DETAILS

Question	Details

EXAMINATION – to be completed by the Clinician

General examination – Respiratory system

Any lymphadenopathy, obvious respiratory distress, cyanosis, clubbing

Examination of chest

Chest expansion – good or restricted, percussion note, air entry, any added sounds/wheeze/crepitations)

Additional observations

Current respiratory infections, spirometry technique etc)

PA Chest X-ray result/outcome

Date of X-Ray:

OUTCOME OF RCS ASSESSM|ENT	☐ FIT	☐ Refer	☐ Unfit

Signature of doctor	Date of examination

SECTION 12 AUDIOMETRY SURVEILLANCE

Please answer all questions. If yes, please give further details in the space provided.

	YES	NO	Details (continue below if needed)
1. Do you currently work in any noisy areas where hearing protection is available, or must be worn?	☐	☐	

If you have answered NO to question 1 you do not need to complete the rest of this section. Please go to next section.

PERSONAL & FAMILY HISTORY	YES	NO	Details (continue below if needed)
1. Do you have difficulty hearing?	☐	☐	
2. If yes: Does it make it difficult for you to participate in conversations or use the telephone?	☐	☐	
Do you have difficulties communicating when working in noisy environments?	☐	☐	
3. Have you noticed any recent change in your hearing?	☐	☐	
4. Do you experience frequent tinnitus (ringing or buzzing in your ears more than once a week)	☐	☐	
5. Have you previously worked in a noisy job?	☐	☐	
6. Are you exposed to loud noise through any activities outside work?	☐	☐	
7. Have you ever had an injury or operation to either ear?	☐	☐	
8. Have you ever had a serious head injury?	☐	☐	
9. Have you suffered from an illness which has affected your hearing?	☐	☐	
10. Have you been seen by an ENT specialist?	☐	☐	
11. Is there any family history of hearing problems?	☐	☐	
12. In the past 3 days have you had a cold, flu or sinus condition?	☐	☐	
13. Have you been exposed to noise in the last 12 hours? (If so, was hearing protection used)	☐	☐	

PREVIOUS EXPOSURE / PPE USE	YES	NO		YES	NO
Service in Armed Forces?	☐	☐	Hearing protection available if req'd?	☐	☐
Exposure to gunfire?	☐	☐	Currently use hearing protection?	☐	☐
Exposure to explosions?	☐	☐	Hearing protection used in the past?	☐	☐
Exposure to engine noise?	☐	☐	Hearing aid used?	☐	☐

FURTHER DETAILS

Question	Details
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

SECTION 13 HAND-ARM VIBRATION (TIER 2)

Please answer all questions. If yes, please give further details in the space provided.

Please note that current HAVS regulations require HAV-exposed workers to have a more detailed HAVS assessment periodically, and you will be further notified if this is required.

		YES	NO	Details (continue below if needed)
1.	Have you been using hand-held vibrating tools, machines or hand-fed processes in your job, or if this is a review, since your last assessment? If yes, please describe type of tool & nature of use	☐	☐	
2.	If yes, have you used these tools in the last two years?	☐	☐	
	If you have not been using tools, or it is more than two years since your last exposure (ie have answered NO to questions 1 & 2 above) you do not need to complete the rest of this section.			
3.	Do you experience any or tingling in your fingers lasting more than 20 minutes after using vibrating equipment?	☐	☐	
4.	Do you experience numbness or tingling in your fingers at any other time?	☐	☐	
5.	Do you wake up at night with pain, tingling or numbness in your hand or wrist?	☐	☐	
6.	Have any of your fingers gone white in response to cold exposure?	☐	☐	
7.	Have you noticed any change in your response to your tolerance of working outdoors in the cold?	☐	☐	
8.	Are you experiencing any other problems in your hands or arms?	☐	☐	
9.	Do you have difficulty picking up very small objects, eg screws or buttons, or opening tight jars?	☐	☐	
10.	Has anything changed about your health since your last assessment?	☐	☐	

FURTHER DETAILS

Question	Details

SECTION 14 HAND-ARM VIBRATION (TIER 3)

Please answer all questions. If yes, please give further details in the space provided.
If you are not currently using tools and it is more than two years since your last exposure, you do not need to complete the rest of this section.

	YES	NO	Details
1. Are you right or left handed?			☐ Right ☐ Left
2. Are you currently experiencing problems with your hands/arms? If yes, please specify.	☐	☐	
3. Have you ever had a neck/arm/hand injury (not necessarily at work)? If yes, please state what and when.	☐	☐	
4. Have you ever had an operation on your neck/arm/hand? If yes, please state what and when.	☐	☐	
5. Have you had any serious disease of the joints/nerves/heart or blood vessels? If yes, please give details.	☐	☐	

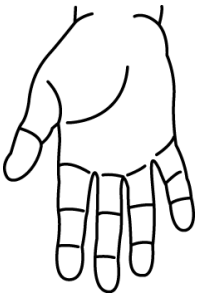
WORK & FAMILY HISTORY	YES	NO	Details
6. Do you currently use vibrating tools in the course of your work?	☐	☐	
7. Have you stopped using vibrating tools within the last 12 months?	☐	☐	
8. Please list which tools you use/used regularly.			
9. Which of the above tools do/did you use most often?			
10. On average, how many hours do you spend in total using vibrating tools each week?	☐ Less than 5 hours per week ☐ Between 5 & 10 hours per week ☐ Between 10 & 20 hours per week ☐ 20 or more hours per week		
11. How many hours did you spend using vibrating tools last week?			
12. How long have you been doing your current job?			

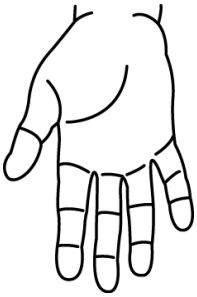
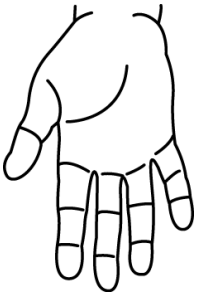
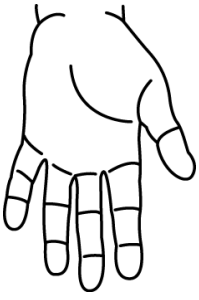
13. Please list below any jobs did you have held outside this company that involved the use of vibrating tools.

	Hours/day	Years
(1)		
(2)		
(3)		
(4)		
(5)		

14. Have you had any exposure to chemicals at work? If yes, please specify.	☐	☐	
15. Do you have any leisure pursuits which expose you to hand-transmitted vibrations? If yes, please specify.	☐	☐	

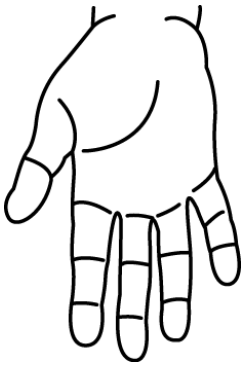
SECTION 14 CONTINUED	YES	NO	Details
16. Do you work in the evening or at weekends with vibrating tools outside of work? If yes, please specify what tools are used.	☐	☐	
17. How many hours/ week do you use vibrating tools outside of work?	In summer: ..... hours / week In winter: ..... hours / week		
18. Is there any family history of circulatory problems?	☐	☐	
19. Have any members of your immediate family suffered from vibration white finger? If yes, please give details.	☐	☐	

SYMPTOMS	YES	NO	Details
BLANCHING			
20. Have you ever experienced any or all of your fingers suddenly becoming cold and numb, and at the same time turning white or pale (blanching)?	☐	☐	
If so:			
- Has this been brought on by cold, damp or wet conditions?	☐	☐	
- During the attack, have you noticed a clear edge between the white or pale part of your finger and the normal colour of your hand?	☐	☐	
- Has this occurred during the past 12 months?	☐	☐	
- How long have you noticed the blanching?			.....
21. If you suffer from blanching, when does this occur?	☐ All the year round ☐ Only in cold weather ☐ Several times a year ☐ Several times a month ☐ Every day ☐ Several times a day		....
22. Is the blanching:	☐ Getting better? ☐ Staying the same? ☐ Getting worse?		
23. Do you experience whiteness in your feet or other periphery? If so, please state where.	☐	☐	
24. Please mark which parts of your fingers are affected by blanching.	Right hand 		Left hand 

SECTION 14 CONTINUED	YES	NO	Details
TINGLING			
25. Do you suffer from tingling of the fingers? Exclude tingling that lasts for less then 20 minutes after using vibrating tools.	☐	☐	
If so:			
- Does this occur in response to cold?	☐	☐	
- Does this occur at the same time as blanching?	☐	☐	
- Does this occur whilst you are working?	☐	☐	
26. Does the tingling occur at any other times (eg at night) or disturb your sleep? If so, when does this occur/how long does it last?	☐	☐	
27. Do you have any tingling or pain in your forearm (between wrist and elbows)?	☐	☐	
28. How long have you suffered from tingling?			
29. Is the tingling:	☐ Getting better? ☐ Staying the same? ☐ Getting worse?		
30. Please mark which parts of your fingers are affected by tingling.	Right hand 		Left hand 
NUMBNESS			
31. Do you suffer from numbness of the fingers? Exclude transient numbness that lasts for less then 20 minutes after using vibrating tools.	☐	☐	
If so:			
- Does this occur in response to cold?	☐	☐	
- Does this occur at the same time as blanching?	☐	☐	
- Does this occur whilst you are working?	☐	☐	
32. Does the numbness occur at any other times (eg at night) or disturb your sleep? If so, when does this occur/how long does it last?	☐	☐	
33. How long have you suffered from numbness?			
34. Is the numbness:	☐ Getting better? ☐ Staying the same? ☐ Getting worse?		
35. Please mark which parts of your fingers are affected by numbness.	Right hand 		Left hand 

SECTION 14 CONTINUED	YES	NO	Details
36. Do any of these symptoms (blanching, tingling or numbness) affect your work?	☐	☐	
37. Do any of these symptoms affect your leisure activities? If yes, please give details.	☐	☐	
38. Do you have difficulty handling or manipulating small objects? If yes, when does this occur?	☐	☐	
MUSCULOSKELETAL			
39. Are you experiencing any problems with the muscles or joints of your hands / arms / wrists / elbows / shoulders, such as pain, stiffness, swelling or weakness? If so, please give details.	☐	☐	

ASSESSMENT (To be completed by HML staff)	YES	NO	Details
Evidence of blanching?	☐	☐	
Evidence of tingling?	☐	☐	
Evidence of numbness?	☐	☐	
Previous assessment for HAVS?	☐	☐	Date if known: .....

EXAMINATION	RIGHT	LEFT
Appearance of hands Note any signs of vascular disease, deformity, scars, callosities or muscle wasting.		
Circulation: Blood pressure:	..... / .... /	..... / .... / .....
Nervous system: Light Touch: Dexterity: Details of any abnormality:	☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal .....
Function: Grip strength:	1: ..... 2: ..... 3: ..... Average: ..... ☐ Normal ☐ Reduced	1: ..... 2: ..... 3: ..... Average: ..... ☐ Normal ☐ Reduced

SECTION 14 CONTINUED			
SUMMARY		**YES**	**NO**
Vascular:	Evidence or history of blanching?	☐	☐
Neurological:	Indications of neurological impairment present?	☐	☐
	Carpal tunnel syndrome suggested by history or tests?	☐	☐
Musculoskeletal:	Muscular or soft-tissue disorder present?	☐	☐

OUTCOME OF HAVS TIER 3	☐ FIT (Stage 0)	☐ Escalated for further consideration

COMMENTS

Signed	Print name
Position OH Technician / OH Adviser	Date

SECTION 15 TEST RESULTS (This page onwards for completion for HML staff)

BODY MASS

Height: ..... cm BMI: .....

Weight: ..... kg Abdo Circ: ..... cm

GP REFERRAL ☐ OH REVIEW ☐

BP / PULSE

Reading 1: ...../..... Pulse: .....

2: ...../.....

3: ...../..... Average BP: ...../.....

GP REFERRAL ☐ OH REVIEW ☐

GLUCOSE

URINALYSIS ☐ 0 T 1+ 2+ 3+ 4+

BLOOD ☐ ..... mmol/L

GP REFERRAL ☐ OH REVIEW ☐

LUNG FUNCTION

SPIROMETRY ☐

PEAK FLOW ☐

	Measured	% Predicted
FVC		
FEV1		
FEV1/FVC		
PEAK FLOW		

GP REFERRAL ☐ OH REVIEW ☐

VISION

KEYSTONE ☐

SNELLEN ☐

		R	L	B
FAR	UNCORRECTED	6 /	6 /	6 /
	CORRECTED	6 /	6 /	6 /
NEAR	UNCORRECTED	N	N	N
	CORRECTED	N	N	N

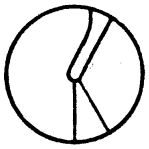
ISHIHARA ☐ CORRECT / INCORRECT /

COLOUR NORMAL ☐ DEFICIENT ☐

OPTICIAN REFERRAL ☐ OH REVIEW ☐

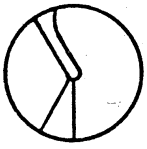
OTOSCOPY

RIGHT	YES	NO
Meatus clear	☐	☐
TM NAD	☐	☐



....

LEFT	YES	NO
Meatus clear	☐	☐
TM NAD	☐	☐



....

AUDIOMETRY

WHISPER TEST ☐ ACCEPTABLE ☐ DEFICIENT ☐

WARBLETONE ☐

✓: Heard

✗: Not heard

	R1k	R2k	R4k	L1k	L2k	L4k
30dB						
50dB						

AUDIOGRAM ☐ HSE (2006): 1 ☐ 2 ☐ 3 ☐ 4 ☐ U ☐

GP REFERRAL ☐ OH REVIEW ☐

MUSCULO-SKELETAL ASSESSED ☐ ACCEPTABLE ☐ DEFICIENT ☐

☐ ☐

OPTIONAL WELLBEING MEASUREMENTS

CHOLESTEROL

TC: ..... mmol/L

HDL: ..... mmol/L

} TC:HDL Ratio: .....

GP REFERRAL ☐

CVR RISK

LOW RISK ☐ AR < 10% and RR < 50

MODERATE RISK ☐ AR 10 -20% or RR 50 - 80

HIGH RISK ☐ AR > 20% or RR > 80

☐

SECTION 16 CHESTER STEP TEST – PRE-ASSESSMENT QUESTIONNAIRE

To be completed with HML staff on day of assessment only

The Chester Step test is a form of exercise test. Any physical activity, particularly for those that do not exercise regularly, may increase the risk of injury. These questions are designed to identify those individuals where medical advice may be beneficial prior to starting an exercise test. It is therefore important that each question in answered accurately and honestly.

		YES	NO	Details (continue below if needed)
1.	Has a doctor ever advised you that you have a heart condition and recommended only medically supervised physical activity?	☐	☐	
2.	Do you suffer from chest pain brought on by physical activity?	☐	☐	
3.	Do you have a tendency to lose consciousness or fall over as a result of dizziness?	☐	☐	
4.	Has your doctor ever recommended medication for your blood pressure or heart condition?	☐	☐	
5.	In the past month, have you experienced chest pain when you were not doing physical activity?	☐	☐	
6.	Do you have a bone or joint problem that could be aggravated by repeatedly stepping on and off a step of the height used for testing?	☐	☐	
7.	Are you aware, through your own experience or a doctor's advice, of any other physical reason for not undertaking the assessment?	☐	☐	

If you have answered yes to any of the above questions, it may be necessary to seek the advice of a doctor prior to undertaking the Chester Step Test.

SUMMARY (To be completed by HML staff)

Technician assessment:	☐ Suitable for CST	☐ Doctor review required
Doctor contacted prior to assessment:	☐ No	☐ Yes
Name of doctor contacted:		
Doctor recommendation (where applicable):	☐ Suitable for CST	☐ Unsuitable for CST

COMMENTS

Signed	Print name
Position OH Technician / OH Adviser	Date

SUBJECT DECLARATION

I have read, understood and completed the above pre-assessment questionnaire, and have had opportunity to raise any questions or concerns regarding the test process, which have been answered to my satisfaction.

Signed		Date	

SECTION 17 ASSESSMENT OUTCOME

An outcome must be provided for each assessment requiring completion. OH review should be requested if:

- further assessment may be necessary in order to determine fitness
- it would be inappropriate to report simply as FIT with no additional information
- an outcome cannot be given as an assessment item could not be completed

HEALTH SURVEILLANCE:

RESPIRATORY	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
SKIN	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
AUDIOMETRY	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
HAVS TIER: ☐	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW

FITNESS FOR WORK:

COLD STORE	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
DRIVER/FLT	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
BA/CONFINED SPACE	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
SAFETY CRITICAL WORK	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
WORK AT HEIGHTS	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
NIGHT-WORKER	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
MAN HANDLING	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
EU HYGIENE	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
.....	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
.....	☐ NOT ASSESSED	☐ ACCEPTABLE	☐ FOR OH REVIEW
WELLNESS	☐ NOT INCLUDED	☐ COMPLETED	☐ DECLINED

PLEASE COMPLETE IF MARKED FOR OH REVIEW

Employee escalation sheet issued: ☐ Yes ☐ No

Preferred method of contact for COT update:
☐ No update requested
☐ By post to home address given on front page

COMMENTS

.....

.....

.....

.....

.....

.....

.....

Signed	Print name
Position OH Technician / OH Adviser	Date

SECTION 18 EMPLOYEE CONSENT & DECLARATION

I declare that the information given by me is accurate and true to the best of my belief and knowledge, and that I have not omitted or falsified any material facts or details which could have a bearing upon my state of health.

I understand my employer has a legal obligation to carry out health surveillance as a result of my being exposed to identified hazards at work, and that I have a legal and contractual obligation to comply with arrangements that my employer has made in respect of health surveillance.

In view of the above I understand that specific refusal on my part to allow feedback to my employer on the results of health surveillance may result in decisions being made regarding my employment without the benefit of objective evidence, and thus may not be in my best interests.

*I **DO/ DO NOT** give my consent for Health Management Ltd to advise my employer on my current medical fitness to undertake my role. Only information relevant to this advice will be shared with my employer.*

*I **DO/DO NOT** give consent for relevant information identified during this assessment to be passed on to my General Practitioner where this is considered advisable to assist my GP in supporting my health & wellbeing*

I understand that information given on this questionnaire will be assessed in confidence by medical staff of Health Management Ltd, and held in strict confidence in accordance with the Data Protection Act (1998), and give my consent within the meaning set out in the Data Protection Act (1998) for Health Management Ltd to process my personal information for the sole purposes stated above.

Signed	Date .....

Head office: Ash House
The Broyle
Ringmer
East Sussex. BN8 5NN
T: 0845 504 1000

Birmingham: 2 Home Farm Courtyard
Meriden Road
Berkswell
Coventry. CV7 7SH
T: 0845 504 0230

healthmanagement
A MAXIMUS Company