CONFIDENTIAL

CATEGORY 2 (Safety Critical Worker)

AUTHORISED HEALTH PROFESSIONAL HEALTH ASSESSMENT CHECK LIST

☐ **Has the declaration sections on pages 3 and 6 of the Health Assessment Form been signed by the candidate.**

☐ **Has the Safety Critical Worker - Health Questionnaire been completed.**

☐ **Have the following pathology tests been ordered.**

- **Urine drug screen.**
- **Alcohol Breath Test.**

☐ **Audiometric Examination Conducted. (Unless already organised by the employer)**

HEALTH ASSESSMENT FORM

CATEGORY 2 (Safety Critical Worker)

SECTION 1: EMPLOYER TO COMPLETE

1.1 Employee/Applicant Details	
Surname:	***First Names:***
Location:	
Company Employment Number:	***Date Of Birth:***
Prospective/Current Position:	

1.2 Employer Details		
Supervisor/Contact:		
Date of Request:	***Phone:***	***Fax:***
Account to be sent to:		

1.3 Health Assessment Appointment Details	
Health Professional:	
Address:	
Phone:	***Fax:***
Appointment Date:	***Appointment Time:***

Tests Required:

- ☐ • **Urine Drug Screening**
- ☐ • **Audiometry**
- ☐ • **Alcohol Breath Test**

1.4 Description of Duties (or see attached Job Description or Task Risk Assessment)

☐ ***Rail Safety Worker Risk Assessment Attached***

Description:	

1.5 Type of Assessment Required:

☐	Pre-employment / Change of Category Health Assessment
☐	Periodic Health Assessment
☐	Triggered Health Assessment (specify reason):

SECTION 2: EMPLOYEE/APPLICANT MUST READ AND COMPLETE

2.1 Important Information to the employee/applicant

- You are required to attend a health assessment to assess your fitness for undertaking rail safety work.
- The health assessment must be completed by the date shown in section 1.3 of this form to ensure that you are able to carry out your normal duties.
- You are required to complete section 3.1 (Safety Critical Worker – Health Questionnaire) of this form BEFORE ATTENDING THE HEALTH ASSESSMENT APPOINTMENT and provide it to the examining health professional. **You must sign the declaration at 3.2 of the health questionnaire section of this form in the presence of the examining health professional.**
- Take glasses, hearing aids or any other aids required for safety critical work to the appointment.
- Take all medication that you are currently taking to the appointment or a list of such medication.
- Take photo identification with you to the appointment.

  As you are a **Safety Critical Worker (Category 2)** you will required to have a hearing and vision (including colour vision) test and breathing test (spirometry)

  You should not be exposed to loud noise16 hours prior to the audiometric test.

  A urine sample will also be required for drug screening purposes. Avoid excessive intake of water prior to providing urine sample.

What happens if the examining health professional finds a problem with your health?

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

If the examining health professional finds that you do not meet all relevant medical criteria, your supervisor will discuss with you the appropriate action to be taken.

DISCLOSURE OF HEALTH INFORMATION – PLEASE READ CAREFULLY AND SIGN TO INDICATE YOUR UNDERSTANDING OF HOW YOUR HEALTH INFORMATION IS REPORTED, STORED AND ACCESSED

The details of your health assessment will remain confidential and will only be reported to your employer in terms of your fitness for duty.

The examining health professional will retain all detailed health assessment papers including your responses to the questionnaire, test results and the completed record of clinical findings.

The Examining Health Professional will review the clinical findings and test results and will provide a recommendation to your employer only in terms of your fitness for duty. This recommendation will be by way of the Recommendation Of Examining Health Professional Form.

The Examining Health Professional will maintain confidentiality of the records and will ensure they are not made available to, or discussed with any other person within your company other than that person authorised to receive such results.

Other than the above, no information will be disclosed to any other person or organisation without your written permission except where;

- A notifiable disease is diagnosed which must, by law, be reported to the state authorities;
- A report is subpoenaed by a court of law; or
- The rail safety regulator (or another person) is required to conduct an inquiry into a railway accident or incident.

You have the right to access your health records, including those held by the authorised health professional, the Specialist In Occupational Medicine and reports held by ARG.

EMPLOYEE/APPLICANT DECLARATION

I, _____ (print Name)

Certify that I have read and understand the above statement concerning the health information provided herein.

Signature:_____

Date: _____

SECTION 3: EMPLOYEE/APPLICANT TO COMPLETE

3.1 Safety Critical Worker – Health Questionnaire

The questions on the following pages must be completed in order to help assess your fitness to work.

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.
All questions must be answered truthfully.

	NO	YES
1. Are you currently being treated by a doctor for any illness or injury?	☐	☐
2. Are you receiving any medical treatment or taking any medication (prescribed or otherwise)? *(Please take any medications with you to show the doctor) Please note brief details*	☐	☐

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

		NO	YES			NO	YES
3.1	High blood pressure	☐	☐	3.15	Colour blindness	☐	☐
3.2	Heart disease	☐	☐	3.16	Kidney disease	☐	☐
3.3	Chest pain, angina	☐	☐	3.17	Diabetes	☐	☐
3.4	Any condition requiring heart surgery	☐	☐	3.18	Neck, back or limb disorders	☐	☐
3.5	Palpitations/irregular heartbeat	☐	☐	3.19	Hearing loss or deafness or had an ear operation or use a hearing aid?	☐	☐
3.6	Abnormal shortness of breath	☐	☐	3.20	Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?	☐	☐
3.7	Do you smoke or have you ever been a smoker?	☐	☐	3.21	Have you ever had, or been told by a doctor that you had a psychiatric illness or nervous disorder?	☐	☐
3.8	Head injury, spinal injury	☐	☐	3.22	Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?	☐	☐
3.9	Seizures, fits, convulsions, epilepsy	☐	☐	3.23	Do you use illicit drugs?	☐	☐
3.10	Blackouts or fainting	☐	☐				
3.11	Migraine	☐	☐				
3.12	Stroke	☐	☐				
3.13	Dizziness, vertigo, problems with balance	☐	☐				
3.14	Double vision, difficulty seeing	☐	☐				

4. Please tick the box 'NO' or 'YES' in response to the following:	NO	YES
4.1 Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy?	☐	☐
4.2 Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐	☐

Epworth Sleepiness Scale:

4.3 How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers 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.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze off **2 = moderate chance of dozing**
1 = slight chance of dozing **3 = high chance of dozing**

		Chance of Dozing (0 – 3)			
	SITUATION	**0**	**1**	**2**	**3**
4.3.1	Sitting and reading	❑	❑	❑	❑
4.3.2	Watching TV	❑	❑	❑	❑
4.3.3	Sitting, inactive in a public place (eg. a theatre or meeting)	❑	❑	❑	❑
4.3.4	As a passenger in a car for an hour without a break	❑	❑	❑	❑
4.3.5	Lying down to rest in the afternoon when circumstances permit	❑	❑	❑	❑
4.3.6	Sitting and talking to someone	❑	❑	❑	❑
4.3.7	Sitting quietly after a lunch without alcohol	❑	❑	❑	❑
4.3.8	In a car, while stopped for a few minutes in the traffic	❑	❑	❑	❑

5. AUDIT Questionnaire **Please circle the response that is correct for you:**

		(0)	(1)	(2)	(3)	(4)
5.1	How often do you have a drink containing alcohol?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
5.2	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 5	5 to 6	7 to 9	10 or more
5.3	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
5.4	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
5.5	How often during the last year have you failed to do what was normally expected from 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
5.6	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
5.7	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
5.8	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
5.9	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

5.10	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

6.	K10 Questionnaire	Please tick the answer that is correct for 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)**
6.1	In the past 4 weeks, about how often did you feel tired out for no good reason?	❑	❑	❑	❑	❑
6.2	In the past 4 weeks, about how often did you feel nervous?	❑	❑	❑	❑	❑
6.3	In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	❑	❑	❑	❑	❑
6.4	In the past 4 weeks, about how often did you feel hopeless?	❑	❑	❑	❑	❑
6.5	In the past 4 weeks, about how often did you feel restless or fidgety?	❑	❑	❑	❑	❑
6.6	In the past 4 weeks, about how often did you feel so restless you could not sit still?	❑	❑	❑	❑	❑
6.7	In the past 4 weeks, about how often did you feel depressed?	❑	❑	❑	❑	❑
6.8	In the past 4 weeks, about how often did you feel that everything was an effort?	❑	❑	❑	❑	❑
6.9	In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	❑	❑	❑	❑	❑
6.10	In the past 4 weeks, about how often did you feel worthless?	❑	❑	❑	❑	❑

In the past 4 weeks, have there been any extraordinary events in your life that may have particularly affected your responses to the questions in sections 1 and/or 3 (for example: death of a friend/family member, victim of crime, birth of a child, physical / psychological illness, etc)?

PLEASE NOTE:
The examinee has the right to refuse permission to contact their GP however, this may result in the process for Recruitment and Selection for the position that they have applied for being suspended or ceased.

3.2 Declaration (To be signed by the employee/applicant in the presence of the Examining Health Professional)

I, _____(Print Name)

- Certify that to the best of my knowledge, the above information supplied by me is true and correct.
- ❑ give ❑ do not give **(please indicate)** permission for the examining health professional to contact my treating doctor(s) to discuss or clarify information relating to my current health status.

Employee/Applicant Signature:_____ Date:_____

Examining Health Professional

Name:_____

Signature:_____ Date:_____

SECTION 4: IMPORTANT INFORMATION TO THE EXAMINING HEALTH PROFESSIONAL

4.1 Instructions To the Examining Health Professional

- You are requested to conduct a **category 2** health assessment to assess the employee/applicants fitness for rail safety duties in accordance with the *National Standard for Health Assessment of Rail Safety Workers, Volume 2: Assessment Procedures and Medical Criteria.*
- You must sight photo identification of the employee/applicant (eg Drivers Licence, Rail Safety Workers' Card)
- Please perform the assessment and record the finding in section 4.2 of this form and then, forward the competed Recommendation Of Examining Health Professional Form to the company arranging the health assessment.
- Should the employee/applicant be assessed as Temporarily/Permanently Unfit for Duty, please contact the person responsible for arranging this health assessment immediately so that appropriate actions can be taken.
- Category 2 Safety Critical employees/applicants are required to have audiometric and vision (including colour vision) testing as part of this health assessment. The employee/applicant has been advised of these requirements in section 2 of this form.

  These tests will be arranged separately and reports forwarded to you if facilities are not are not available at your practice.
- You may need to contact the employee/applicants nominated health professional to discuss conditions that may affect their fitness for rail safety work. Such contact should only be made with the workers signed consent.

For more detailed information about the conduct of health assessments for rail safety employees see *Volume 2 of the National Standard for Health Assessment of Rail Safety Workers.*

4.2 Category 2 Safety Critical Worker Health Assessment Examination – Examining Health Professional To Compete

1. Cardiovascular System:

1.1 Blood Pressure

Systolic ☐ mm Hg

Diastolic ☐ mm Hg

1.2 Pulse Rate: ☐ Regular ☐ Irregular ☐

1.3 Heart Sounds: Normal ☐ Abnormal ☐

1.4 Peripheral Pulses: Normal ☐ Abnormal ☐

2. Chest/Lungs: Normal ☐ Abnormal ☐

3. Abdomen (liver): Normal ☐ Abnormal ☐

4. Medications:(Record details of medications from Question 2 of the Health Questionnaire section 3 of this form)

5. Neurological/Locomotor:

5.1 Cervical spine rotation Normal ☐ Abnormal ☐

5.2 Back movement Normal ☐ Abnormal ☐

5.3 Upper Limbs

a) Appearance: Normal ☐ Abnormal ☐

b) Joint movements: Normal ☐ Abnormal ☐

5.4 Lower Limbs

a) Appearance: Normal ☐ Abnormal ☐

b) Joint movements: Normal ☐ Abnormal ☐

5.5 Gait Normal ☐ Abnormal ☐

5.6 Romberg's Test (A pass requires the ability to maintain balance while standing with shoes off, feet together side by side, eyes closed and arms by sides, for thirty seconds): Normal ☐ Abnormal ☐

6. Urinalysis

6.1 Protein: Normal ☐ Abnormal ☐

6.2 Glucose: Normal ☐ Abnormal ☐

KHz	0.5	1.0	1.5	2.0	3.0	4.0	6.0	8.0
Left								
Right								

Has the applicant been quiet for the past 16 hours? Y ❑ N ❑

8. Drug Screen:

	NEG	POS		
Creatinine	☐	☐	_____	mmol/L
Sympathomimetic Amines	☐	☐	_____	ng/mL
Barbiturates (non-AS4308)	☐	☐	_____	ng/mL
Benzodiazepines	☐	☐	_____	ng/mL
Cocaine	☐	☐	_____	ng/mL
Methadone (non-AS4308)	☐	☐	_____	ng/mL
Cannabinoids	☐	☐	_____	ng/mL
Opiates	☐	☐	_____	ng/mL
Alcohol	☐	☐	_____	mg%

9. Sleep: Epworth Sleepiness Scale

(Record results from Question 4 of the Health Questionnaire)

Question			
Q 4.3.1		Q 4.3.5	
Q 4.3.2		Q 4.3.6	
Q 4.3.3		Q 4.3.7	
Q 4.3.4		Q 4.3.8	
TOTAL SCORE:			

10. Weight: _____ **Kg**

Height: _____ **cm**

11. Alcohol: Audit Questionnaire

(Record results from Question 5 of the Health Questionnaire)

Question			
Q 5.1		Q 5.6	
Q 5.2		Q 5.7	
Q 5.3		Q 5.8	
Q 5.4		Q 5.9	
Q 5.5		Q 5.10	
TOTAL SCORE:			

12. Psychological Health:

12.1 K 10 Questionnaire

(Record results from Question 6 of the Health Questionnaire)

Question			
Q 6.1		Q 6.6	
Q 6.2		Q 6.7	
Q 6.3		Q 6.8	
Q 6.4		Q 6.9	
Q 6.5		Q 6.10	
TOTAL SCORE:			

12.2 Is attitude, speech and behaviour appropriate?

No ☐ Yes ☐

13. **Vision:**

13.1 Visual Acuity

Uncorrected		Corrected	
R	L	R	L
6/	6/	6/	6/

Are contact lenses worn? No ☐ Yes ☐

13.2 Visual Fields *(Confrontation to each eye):*

Normal ☐ Abnormal ☐

13.3 Colour vision

(Ishihara: ≥ 2 errors/12 plates is a fail)

Pass ☐ Fail ☐

13.4 Near Vision Test Pass ☐ Fail ☐

13.5 Far Vision Test Pass ☐ Fail ☐

13.6 Screen Based Examination Pass ☐ Fail ☐

RELEVANT CLINICAL FINDINGS AND ACTION

Note Comments on any relevant findings detected in the questionnaire or examination, making reference to the requirements of the standard.

I certify that I have examined the person named in accordance with the medical standards contained in the *National Standard for Health Assessment of Rail Safety Workers, Volume 2: Assessment Procedures and Medical*, and in my opinion the worker / applicant is (tick as appropriate):

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

Name of Examining Health Professional: **Signature:**

Note to examining Health Professional *– The results of this health examination are* ***not*** *to be returned to the company who arranged the health assessment,* ***only*** *the Recommendation Of Examining Health Professional Form (Page 10). A copy of these forms may be retained for your records.*

I have sighted the employee / applicant's photo ID ❑

RECOMMENDATION OF EXAMINING HEALTH PROFESSIONAL

I certify that I have reviewed the Health Assessment Examination Form for the person named in accordance with the medical standards contained in the *National Standard for Health Assessment of Rail Safety Workers, Volume 2: Assessment Procedures and Medical*, and in my opinion the worker / applicant is (tick as appropriate):

Worker's Name:_____ **Date Of Birth** ____/____/____ **Employment Number**_____

❑ **Fit for Duty**

Meets all relevant medical criteria for;

❑ Category **2** (Safety Critical Worker)

I recommend:

❑ **Medical Review in** ..... **years**

❑ Local doctor referral
❑ Conditional on corrective lenses
❑ Conditional on hearing aid
❑ Other condition (specify): .....

❑ **Fit for Duty, Subject to Review**
Does not meet all medical criteria, but could perform the inherent requirements of the position if the condition is sufficiently under control and worker / applicant is more frequently reviewed than prescribed under periodic review

If pre employment – Recruitment & Selection process suspended. Risk Assessment required prior to engagement

I recommend:

❑ **Medical Review in** ..... **years**

❑ Specialist referral
❑ Local doctor referral
❑ Company Medical Officer referral
❑ Laboratory tests

This certificate is valid until: .....

❑ **Fit for Duty, Subject to Job Modification**
Does not meet all medical criteria, but could perform the inherent requirements of the position if suitable modifications were made to the duties

If pre employment – Recruitment & Selection process suspended. Risk Assessment required prior to engagement

I recommend the following job modifications:

❑ **Temporarily Unfit for Duty, Subject to Review**
Does not meet all medical criteria and cannot perform the inherent requirements of the position, but may perform alternative duties. May return to full duty pending improvement in condition, response to treatment, confirmed diagnosis of undifferentiated illness

If pre employment – Recruitment & Selection process ceased. May reapply for position when noticeable improvement in condition is verified by applicant's doctor. Re-examination for pre-employment will be required.

I recommend the following in terms of management and review:

❑ **Permanently Unfit for Duty**
Does not meet the medical criteria and cannot perform the job in the future

If pre employment – Recruitment & Selection process ceased.

I recommend the following in terms of management and review:

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

Name of Examining Health Professional: **Signature:**

Please forward completed form to employer. A copy is to be retained for Examining Health Professional medical records.