



## Pre Employment Medical Assessment

### CONFIDENTIAL HEALTH ASSESSMENT

#### PATIENT / EXAMINEE DETAILS

Name: \_\_\_\_\_ M / F \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_

Referred by: \_\_\_\_\_ Site: \_\_\_\_\_

#### SECTION 1 – Examination Type

☐ Pre-employment

☐ Injury Management

#### SECTION 2 – Identity Verification [ Medical practice to complete ]

Driver's licence no.: \_\_\_\_\_ Checked by: \_\_\_\_\_

#### SECTION 3 – Declaration (Patient / examinee to complete)

I \_\_\_\_\_ declare that the information given by me on this form is, to the best of my knowledge, true and complete. I am, to the best of my knowledge, fit for the position described on this form. I give consent for the information contained on this form to be provided to my (prospective) employer with advice from the assessing doctor(s) regarding my appropriate placement at work.

Signed: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Witness: \_\_\_\_\_

#### SECTION 4 – Assessment (Doctor to complete)

☐ the examinee is FIT for the current / proposed position

☐ the examinee is UNFIT for the current / proposed position

☐ the examinee has a condition which results in the following RESTRICTION(S);

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OTHER COMMENTS (Attach separate sheet of space if insufficient)

\_\_\_\_\_  
Doctor's signature

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date



## MUSCULOSKELETAL ASSESSMENT

All test performed within a pain free range. Not timed unless indicated.

Performance of these physical tests will provide an indication of the applicants ability to meet the physical demands of the job within BioGiene Pty Ltd.

Examinee: \_\_\_\_\_

Employer: \_\_\_\_\_

Anatomy:	Comment:	Normal	Abnormal
Scoliosis			
Lordosis / Kyphosis			
General ROM (touching toes, thoracic trunk rotation / cervical)			
Gait			
Upper ROM, shoulder impingement			
<b>General Strength assessments:</b>	<b>Ability:</b>	<b>Comments:</b>	
<ul style="list-style-type: none"> <li>Squat – clockwise/anti clockwise</li> <li>Grip Strength</li> <li>Shoulder Strength – push ups – 10</li> <li>Moving items onto bench, whilst maintaining squat position</li> <li>Bilateral leg raise – 25</li> <li>Back extension – hold for 2 mins</li> <li>Five full sit ups</li> <li>Full squats – 10</li> </ul>	<p>Yes No</p> <p>Right: Excellent Average Below Average</p> <p>Range:</p> <p>Left: Excellent Average Below Average</p> <p>Yes No Not performed</p> <p>Yes No Agility observed</p> <p>Yes No Not performed</p> <p>Yes No Held for:</p> <p>Able to perform: Yes No</p> <p>Able to perform: Yes No Not performed</p>		
<b>Manual handling and gross strength:</b>	<b>Goal: Loads and reps as noted. Weights noted.</b>	<b>Achieved</b>	
		<b>Yes</b>	<b>No</b>
Waist to above shoulder	Maximum lifted: 20kg No. or repetitions:		
40cm above floor, to floor – over 1 mtr	Maximum lifted: 15kg No. of repetitions:		
Unilateral carry load approx. 5 mtrs	Maximum lifted:		
<b>Manual handling technique</b>			

Able to complete all exercises as requested:

Yes

No

Recommendations:

Assessment conducted by: \_\_\_\_\_

Date: \_\_\_\_\_



## DRUGS OF ABUSE (URINE) INITIAL SCREEN, BREATH ALCOHOL CONCENTRATION

Donor: \_\_\_\_\_ M / F DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer: \_\_\_\_\_

### HISTORY (Donor to complete. Please tick relevant boxes)

1. Are you taking any drugs prescribed by a Doctor? ☐ No ☐ Yes – If yes please provide details:

Drug name	Strength (eg milligrams)	Dose per day	How long have you used the medication	Last dose (date/time)
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2. Are you taking any over the counter drugs? ☐ No ☐ Yes – If yes please provide details:

Drug name	Strength (eg milligrams)	Dose per day	How long have you used the medication	Last dose (date/time)
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3. Please list any other drugs or medication you are taking, but have not previously mentioned.

4. Other comments or explanations

### DONOR CERTIFICATION (Donor to complete)

I certify that the specimens accompanying this form are my own and were provided by me to the collector. Further, I certify that the specimen containers were sealed with tamper proof seals in my presence (only applicable if samples are to be shipped to laboratory for further analysis) and that the information provided in this form and on the labels is correct. I consent to the analysis of the specimens for alcohol and other drug abuse and the release of these results to (1) my employer or prospective employer, (2) my employer's medical officer (doctor)

Signature of donor ..... Date ...../...../.....

### COLLECTION CERTIFICATION (Collector of the specimen to complete)

Date of collection ...../...../..... Time of collection ..... am / pm

Specimen temperature (read within 4 mins of collection) ..... deg. C (Acceptable = 33.0 to 38.0)

Duplicate specimen provided to donor (if requested) ☐ No ☐ Yes

Specimen referred to laboratory ☐ No ☐ Yes – serial number of seals .....

### RESULTS – PRELIMINARY SCREEN (Results are marked by a tick in appropriate box(s))

1. ☐ Not preformed

2. ☐ All clear

3. ☐ Positives - ☐ CAN ☐ COC ☐ SYM ☐ OPIATES ☐ BENZ

NOTE: "CAN" = cannabinoids, "COC" = cocaine metabolites, "SYM" = sympathomimeticamines,  
"BENZ" = benzodiazepines

Test kit: \_\_\_\_\_ Lot No.: \_\_\_\_\_ Expiry date: \_\_\_\_\_

BAC (if performed): .....

Have you consumed any alcohol within the last 24hrs, if so, how many standard drinks? .....

I certify that the specimen identified on this form is that provided to me by the donor providing the certification above, that it bears the same identification as set forth above and that it has been collected, divided, labelled and sealed in accordance with Australian Standard AS 438:201

.....	.....	.....	...../...../.....
Signature of collector	Signature of doctor	Name of doctor	Date



## DRUGS OF ABUSE TEST REPORT

Patient: \_\_\_\_\_

Address: \_\_\_\_\_

DOB: \_\_\_\_\_ M / F

Occupation: \_\_\_\_\_ BioGiene Pty Ltd

Report for: BioGiene Pty Ltd

Test(s): DRUGS OF ABUSE (URINE) – INITIAL SCREEN (IMMUNO – ASSAY)  
BREATH ALCOHOL

Collected: \_\_\_\_\_

Specimen: Urine, random

Test Kit: Instant view  
Expiry: \_\_\_\_\_  
Lot no.: \_\_\_\_\_

DRUG / METABOLITE	Detected	( Yes / No )
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Cannabinoids	Yes / No
Cocaine metabolites	Yes / No
Sympathomimetic amines	Yes / No
Opiates	Yes / No
Benzodiazepines	Yes / No

Analysis performed in accordance with the initial test cut off limits specified in Australian Standard 4308.

Breath alcohol concentration: \_\_\_\_\_

BAC analysis performed in accordance with requirements specified in Australian Standards AS3547 Type 2 devices, calibration certificate number 15236.

FURTHER TESTING: \_\_\_\_\_

ADMITTED DRUGS: \_\_\_\_\_

DOCTOR'S COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

Further information: Dr \_\_\_\_\_, Specialist in Occupational Medicine

\_\_\_\_\_  
Signature of doctor Date

Name of services provided by: \_\_\_\_\_  
\_\_\_\_\_