

Dear Applicant

In the interests of your ongoing health and wellbeing, and as a condition of your employment, you are required to attend an assessment of your fitness to undertake rail safety work.

This health assessment is guided by the National Standards for Health Assessment of Rail Safety Workers (October 2012) as set by the National Transport Commission.

Please bring with you before attending the health assessment:

- All information relating to any current and pre-existing medical conditions (i.e. specialist reports, diabetes management plans, fitness for work plans, weight management plans etc);
- Prescription glasses (if you wear them);
- Hearing aids (if you use them);
- A list of your current medication/s? (If you are unsure take the packets with you).

Please also bring with you:

- Photographic ID (Driver's Licence / Passport etc)
- The health questionnaire with section 2 and 3 completed by you.

For purposes of testing drug screening; a urine sample will be required during the health assessment. This is not part of your blood test.

Do not be exposed to loud noise 16 hours prior to audiometric testing.

You will be required to have a blood test which requires you to fast (not eat) for at least 8 hours prior to the blood test. The blood test is to show your Cholesterol Levels (Total and Low density lipids) and blood sugar levels.

A pathology form for you to be able to undertake the blood tests (up to a week prior to your Health Assessment appointment) may be provided to you by the TAPs and Medicals Officer, as well as details of where this blood test can be done. **You must take the pathology form with you when going for your blood test.**

If the examining health professional finds that you do not meet all relevant medical criteria that the standard requires, you will be advised of recommended action you will need to take and the amount of time you have to complete the actions.

The examining Health Professional is not permitted and will not treat any medical condition, but may provide you a letter to give to your own treating General Practitioner and Medical Specialist (if required).

HEALTH ASSESSMENT FORM

CATEGORY 1 (High Level Safety Critical Worker)

SECTION 1: EMPLOYER TO COMPLETE

1.1 Employee/Applicant Details	
<i>Surname:</i>	<i>First Names:</i>
<i>Depot/Location:</i>	<i>Current Position:</i>
<i>Service Number:</i>	<i>Date Of Birth:</i>
1.2 Employer Details	
<i>Supervisor/Contact:</i>	
<i>Date Medical Request :</i>	<i>Phone:</i>
<i>Account to be sent to:</i>	
<i>Results to be sent to:</i>	
1.3 Health Assessment Appointment Details	
<i>Health Professional:</i>	
<i>Address:</i>	
<i>Phone:</i>	<i>Fax:</i>
<i>Appointment Date:</i>	<i>Appointment Time:</i> <small>(please arrive 15 mins prior)</small>
Tests Required:	<input type="checkbox"/> Fasting Cholesterol (Total and HDL) <input type="checkbox"/> Fasting Glucose <input type="checkbox"/> Breath/Blood Alcohol Level <input type="checkbox"/> Resting ECG <input type="checkbox"/> Audiometry <input type="checkbox"/> Urine Sample
1.4 Description of Duties (or see attached Job Description or Task Risk Assessment)	
<input type="checkbox"/> <i>Rail Safety Worker Risk Assessment Attached</i>	
<i>Description:</i>	
1.5 Type of Assessment Required:	
<input type="checkbox"/>	<u>Pre-employment</u> / Change of Category Health Assessment
<input type="checkbox"/>	Periodic Health Assessment
<input type="checkbox"/>	Triggered Health Assessment (specify reason):

SECTION 2: PERMISSION FOR EMPLOYEE/APPLICANT HEALTH INFORMATION DISCLOSURE

DISCLOSURE OF HEALTH INFORMATION AND INDICATION OF EMPLOYEE'S UNDERSTANDING OF HOW THEIR HEALTH INFORMATION IS REPORTED, STORED AND ACCESSED.

The examining Health Professional will retain all health assessment results. The details of the employee's / applicant's health assessment will remain confidential.

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 examining Health Professional.

IMPORTANT

If the examining Health professional finds or suspects an urgent health issue or if they require you to undergo further investigation, testing, or development of management plans with your GP, the Health Professional may wish to contact your own GP.

You have the right to refuse permission for the examining health professional from contacting your GP however; this may result in your health assessment being delayed.

I give do not give (**please tick**) permission for the examining Health Professional to contact my treating doctor (s) to discuss or clarify information relating to my current health status.

Please provide details: Your contact phone number: _____

Your GP phone number: _____ Your GP address: _____

Your Health Professional/Specialist phone number (if applicable):_____

Your Health Professional/Specialist address: _____

I, _____ (print name) certify that I have read and understood the above information.

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.

1. Are you currently being treated by a doctor for any illness or injury? (Please note brief details)

Yes No

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

Yes No

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

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

4. Please tick the 'NO' or 'YES' in response to the following:

		Yes	No
4.1	Have you undergone an Exercise Stress Test within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
	If Yes Where did you have the test? _____		
	When did you have the test? _____		
4.2	Do you smoke or have been a smoker	<input type="checkbox"/>	<input type="checkbox"/>
	If you are an ex-smoker when did you quit? _____		
	How much did/do you smoke? _____		
4.3	Do you use illicit drugs?	<input type="checkbox"/>	<input type="checkbox"/>
	If Yes, please state drugs used and frequency <div style="border: 1px solid black; height: 60px; width: 100%;"></div>		

5. Please tick the box 'No' or 'Yes' in response to the following:

		Yes	No
5.1	Have you ever had, or been told by doctor you had a sleep disorder, sleep apnoea, or narcolepsy?	<input type="checkbox"/>	<input type="checkbox"/>
5.2	Has anyone noticed that your breathing stops or is disrupted by episodes or choking during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>

Epworth Sleepiness Scale:

- 5.3 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 affect you.

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

0 = Would never doze off

2 = Moderate chance of dozing

1 = Slight chance of dozing

3 = High chance of dozing

	Situation	0	1	2	3
5.3.1	Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3.2	Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3.3	Sitting, inactive in a public place (eg. A theatre or meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3.4	As a passenger in a car for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3.5	Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3.6	Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3.7	Sitting quietly after a lunch without alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.3.8	In a car, while stopped for a few minutes in a traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. AUDIT Questionnaire

Please circle the response that is correct for you:

		(0)	(1)	(2)	(3)	(4)
6.1	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
6.2	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
6.3	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
6.4	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
6.5	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
6.6	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
6.7	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
6.8	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
6.9	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
6.10	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

7. 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)
7.1	In the past 4 weeks, about how often did you feel tired out for no good reason?	<input type="checkbox"/>				
7.2	In the past 4 weeks, about how often did you feel nervous?	<input type="checkbox"/>				
7.3	In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	<input type="checkbox"/>				
7.4	In the past 4 weeks, about how often did you feel hopeless?	<input type="checkbox"/>				
7.5	In the past 4 weeks, about how often did you feel restless or fidgety?	<input type="checkbox"/>				
7.6	In the past 4 weeks, about how often did you feel so restless you could not sit still?	<input type="checkbox"/>				
7.7	In the past 4 weeks, about how often did you feel depressed?	<input type="checkbox"/>				
7.8	In the past 4 weeks, about how often did you feel that everything was an effort?	<input type="checkbox"/>				
7.9	In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	<input type="checkbox"/>				
7.10	In the past 4 weeks, about how often did you feel worthless?	<input type="checkbox"/>				

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)?

8. For Existing Employees Only

- | | | |
|--|-----------------------------|------------------------------|
| 8.1 Have you experienced difficult completing any tasks required for your work (eg. Walking on ballast, hearing train instructions). | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 8.2 Have you been involved in any accidents or near misses at work in the period since your last assessment? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

If yes, briefly describe:

PLEASE NOTE:

You have the right to refuse permission to contact your GP however, this may result your health assessment being delayed.

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 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*,
- You must sight photo identification of the employee/applicant (eg Drivers Licence, Rail Safety Workers' Card)
- Should the applicant be assessed as Temporarily/Permanently Unfit for Duty, please contact the employer immediately so that appropriate actions can be taken.
- Category 1 High Level Safety Critical applicants are required to present for fasting cholesterol (total and HDL), fasting glucose, blood alcohol and a resting ECG. Applicants are also required to have audiometric testing as part of this health assessment. The employee/applicant has been advised of these requirements.
These tests will be arranged separately and reports forwarded to you if facilities are not available at your practice.
- You may need to contact the applicants nominated health professional to discuss conditions that may affect their fitness for rail safety work. Such contact should be made with the workers signed consent.

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

4.2 Category 1 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

1.5 Calculation of Cardiac Risk Level (High level SCW examination only). See cardiovascular chapter for scoring.

	Data	Score
Age/sex		
Smoker Yes/No		
Blood Pressure (systolic)		
Fasting Cholesterol	-Total -HDL -Cholesterol Level	
Fasting plasma glucose (diabetes)		
TOTAL SCORE		

Other clinical considerations (refer section 18.2) Cardiovascular Conditions page 59 of Standard) eg symptoms, family and past history, comorbidity, work conditions: _____

Stress ECG

Yes No

Cardiac risk level 5-9% - Does overall risk assessment require Stress ECG?

Cardiac risk level >10% - Refer for Stress ECG

1.5 Resting ECG (Category 1 only) Normal Abnormal

Notes: _____

2. Neurological/Musculoskeletal:

- | | | |
|--|---------------------------------|-----------------------------------|
| 2.1 Cervical Spine rotation | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| 2.2 Back movement | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| 2.3 Upper Limbs | | |
| a) Appearance | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| b) Joint movements | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| 2.4 Lower Limbs | | |
| a) Appearance | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| b) Joint movements | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| 2.5 Gait | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| 2.6 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 <input type="checkbox"/> | Abnormal <input type="checkbox"/> |
| 2.7 Is a functional/practical assessment required? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

3. Chest/Lungs:

Normal Abnormal

4. Hearing:

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? Yes No

5. Vision:

5.1 Visual Acuity

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

Are contact lenses worn? Yes No

5.2 Visual Fields (Confrontation to each eye): Normal Abnormal

5.3 Colour Vision

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

6. Sleep:

6.1 Epworth Sleepiness Scale (from Health Questionnaire)

Score 0-10

- No other symptoms/risk factors/incidents Fit for Duty
 Plus other symptoms/risk factors/incidents Temporarily unfit

Score 11-15

- No other symptoms/risk factors/incidents Fit for Duty
 Plus other symptoms/risk factors/incidents Temporarily unfit

Score ≥ 16

- Fit for Duty
 Temporarily unfit
 Temporarily unfit

6.2 Body Mass Index (BMI)

Weight _____ kg

Height _____ cm

BMI _____ BMI = weight (kg)/Height (m^2)

If BMI is ≥ 40 or ≥ 35 with diabetes or high blood pressure refer for investigation

7. Substance Misuse

7.1 Alcohol: Audit Questionnaire

(Record results from the Health Questionnaire)

Question	Question
Q5.1	Q5.6
Q5.2	Q5.7
Q5.3	Q5.8
Q5.4	Q5.9
Q5.5	Q5.10
TOTAL SCORE:	

7.2 Drug Screen:

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	Negative	Positive	
Creatinine	<input type="checkbox"/>	<input type="checkbox"/>	_____ mmol/L
Sympathomimetic Amines	<input type="checkbox"/>	<input type="checkbox"/>	_____ ng/ml
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	_____ ng/ml
Methamphetamines	<input type="checkbox"/>	<input type="checkbox"/>	_____ ng/ml
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	_____ ng/ml
Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	_____ ng/ml
Cannabinoids	<input type="checkbox"/>	<input type="checkbox"/>	_____ ng/ml
Opiates	<input type="checkbox"/>	<input type="checkbox"/>	_____ ng/ml
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____ mg%

8. Psychological Health:

8.1. K 10 Questionnaire

(Record results from the Health Questionnaire)

Question	Question
Q6.1	Q6.6
Q6.2	Q6.7
Q6.3	Q6.8
Q6.4	Q6.9
Q6.5	Q6.10
TOTAL SCORE:	

8.2. Is attitude, speech and behaviour appropriate?

No Yes

9. Urinalysis:

9.1. Protein: Normal Abnormal

9.2. Glucose: Normal Abnormal

10. Medications:

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

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RELEVANT CLINICAL FINDINGS/RECOMMENDATIONS TO BROOKFIELD RAIL'S CMO

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*.

Name of Examining Health Professional:

Signature:

DATE:

I have sighted the employee / applicant's photo ID

RECOMMENDATION OF CHIEF MEDICAL OFFICER

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*, and in my opinion the worker / applicant is (tick as appropriate):

Worker's Name: _____ Date of Birth: _____ Service Number: _____

Fit for Duty

Meets all relevant medical criteria for:

Category 1 (High Level Safety Critical Worker)

I recommend:

Medical Review in _____ years

Local doctor referral

Conditional on Corrective lenses

Other condition (specify): _____

Fit for Duty

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 by Brookfield Rail prior to engagement

I recommend:

Medical Review in _____

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 by Brookfield Rail prior to engagement

I recommend:

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:

Name of Chief Medical Officer

Signature: Chief Medical Officer's records

Date: