

**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:** huong      **First Names:** nguyen

**Location:**

**Company Employment Number:**      **Date Of Birth:**

**Prospective/Current Position:**

#### **1.2 Employer Details**

**Supervisor/Contact:** Mineral Resources

**Date of Request:**      **Phone:**      **Fax:**

**Account to be sent to:**

#### **1.3 Health Assessment Appointment Details**

**Health Professional:** Dr. Hanh Nguyen

**Address:**

**Phone:** 000      **Fax:**

**Appointment Date:** 19/08/2014      **Appointment Time:** 02:00

**Tests Required:**

- Audiometry
- Urine Drug Screening
- Alcohol Breath Test

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

**Rail Safety Worker Risk Assessment Attached**

**Description:** AAAAAAAAAAAAAAA

#### **1.5 Type of Assessment Required:**

Pre-employment / Change of Category Health Assessment

Periodic Health Assessment

Triggered Health Assessment (specify reason): TTTTTTTTTTTTTTTTTTTTTTTTT

## 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 noise 16 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, nguyenhuong \_\_\_\_\_ (print Name)

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



Signature: \_\_\_\_\_

Date: 21/11/2014 \_\_\_\_\_

## 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?

oooooooooooooooooooo

NO  YES

#### 2. Are you receiving any medical treatment or taking any medication (prescribed or otherwise)?

NO  YES

(Please take any medications with you to show the doctor) Please note brief details  
PPPPPPPPPPPPPPPPPPPPPPPPPPPPPP

#### 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	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3.15 Colour blindness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.2 Heart disease	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3.16 Kidney disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.3 Chest pain, angina	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3.17 Diabetes	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.4 Any condition requiring heart surgery	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3.18 Neck, back or limb disorders	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.5 Palpitations/irregular heartbeat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3.19 Hearing loss or deafness or had an ear operation or use a hearing aid?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.6 Abnormal shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	3.20 Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.7 Do you smoke or have you ever been a smoker?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3.21 Have you ever had, or been told by a doctor that you had a psychiatric illness or nervous disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.8 Head injury, spinal injury	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3.22 Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.9 Seizures, fits, convulsions, epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	3.23 Do you use illicit drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.10 Blackouts or fainting	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
3.11 Migraine	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
3.12 Stroke	<input checked="" type="checkbox"/>	<input type="checkbox"/>			
3.13 Dizziness, vertigo, problems with balance	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
3.14 Double vision, difficulty seeing	<input type="checkbox"/>	<input checked="" type="checkbox"/>			

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

- 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?

NO  YES

### 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**  
**1 = slight chance of dozing**

**2 = moderate chance of dozing**  
**3 = high chance of dozing**

**Chance of Dozing (0 – 3)**

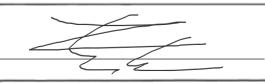
SITUATION	0	1	2	3
4.3.1 Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.3.2 Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.3.3 Sitting, inactive in a public place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

### 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?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
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
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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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.2	In the past 4 weeks, about how often did you feel nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.3	In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.4	In the past 4 weeks, about how often did you feel hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.5	In the past 4 weeks, about how often did you feel restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.6	In the past 4 weeks, about how often did you feel so restless you could not sit still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.7	In the past 4 weeks, about how often did you feel depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.8	In the past 4 weeks, about how often did you feel that everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.9	In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.10	In the past 4 weeks, about how often did you feel worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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)?						
<b>PLEASE NOTE:</b> 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.						
<b>3.2 Declaration (To be signed by the employee/applicant in the presence of the Examining Health Professional)</b>						
I,	nguyenhuong	(Print Name)				
<ul style="list-style-type: none"> <li>Certify that to the best of my knowledge, the above information supplied by me is true and correct.</li> <li><input type="checkbox"/> give <input type="checkbox"/> do not give (<b>please indicate</b>) permission for the examining health professional to contact my treating doctor(s) to discuss or clarify information relating to my current health status.</li> </ul>						
Employee/Applicant Signature:				Date:	21/11/2014	
<b>Examining Health Professional</b>						
Name:	Dr. Hanh Nguyen					
Signature:						
	21/11/2014					

## 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 completed 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 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)  

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#### 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 <input type="checkbox"/>		N <input type="checkbox"/>			

#### 8. Drug Screen:

\_\_\_\_\_

\_\_\_\_\_

	NEG	POS	
Creatinine			mmol/L
Sympathomimetic Amines	<input type="checkbox"/>	<input type="checkbox"/>	ng/mL
Barbiturates (non-AS4308)	<input type="checkbox"/>	<input type="checkbox"/>	ng/mL
Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	ng/mL
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	ng/mL
Methadone (non-AS4308)	<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%

#### 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	
<b>TOTAL SCORE:</b>	0.0		

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	
<b>TOTAL SCORE:</b> 0.0			

#### 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	
<b>TOTAL SCORE:</b> 0.0			

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):

Dr. Hanh Nguyen



Date: 21 /11 /2014

**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):