**FITNESS FOR WORK QUESTIONAIRE**

(Please answer the question or circle the appropriate answer)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*How long have you been employed in this role? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Is your job fly in fly out or drive in drive out?* Yes / No Swing/ Roster \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*What is the name of your site? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*How many numbers of hours per shift? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Are you employed Part time or Full time (Please circle)*

*Permanent or Casual employment (Please circle)*

*Does your role involve* (please circle)

1. *Day shift?* Yes / No
2. *Night shift?* Yes / No
3. *Mixture of day and night shift?* Yes / No

*Have you had any previous operations, fractures, back or musculoskeletal injuries* Yes / No

*If yes, please provide information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*With regards to your current job or your proposed role if this fitness for work is a pre-placement fitness for work, does your role include the following?* *(Please tick the most appropriate)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **Constant** | **Frequent** | **Occasional** |
| **Walking** |  |  |  |  |  |
| **Walking on uneven ground** |  |  |  |  |  |
| **Standing** |  |  |  |  |  |
| **Sitting** |  |  |  |  |  |
| **Reaching and pulling** |  |  |  |  |  |
| **Digging** |  |  |  |  |  |
| **Kneeling and pulling** |  |  |  |  |  |
| **Working in awkward positions** |  |  |  |  |  |
| **Stairs** |  |  |  |  |  |
| **Driving** |  |  |  |  |  |
| **Ladder** |  |  |  |  |  |
| **Working at height** |  |  |  |  |  |

*With regards to the lifting requirements of your role, how many KG would you lift?*

*Floor to waist \_\_\_\_\_\_\_\_\_\_ Waist to shoulder level \_\_\_\_\_\_\_\_\_\_ Above shoulder level \_\_\_\_\_\_\_\_\_\_*

*Exercise Physiologist to complete:*

*Height = \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight = \_\_\_\_\_\_\_\_\_\_\_\_\_\_ BMI = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**AUTHORITY FOR THE RELEASE OF INFORMATION:**

I understand the REDiMED Doctor is an independent Doctor who has been requested by my employer/insurance company to assess my fitness to work.

Should I wish to request a copy of the report, I understand that I will need to request this from the employer/insurance company that has requested the fitness to work examination. I acknowledge I will not be able to access this via the REDiMED Doctor.

I understand that the REDiMED Doctor will not be treating me but is undertaking an assessment of my fitness to work and may make recommendations regarding my fitness, rehabilitation and fitness for full duty employment, as described / requested by my employer/insurer.

I understand that the medical recommendations and report will be made available to my employer/insurance company.

I further understand that if I do not sign all consents below to release information then the fitness for work examination cannot proceed.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ (name) have read the information regarding the fitness for work assessment and give my consent to REDiMED, to contact and release any confidential medical information regarding that nature of my health condition(s) to the employer/insurance company requesting this fitness for work.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

*This signature confirms that I have read the above statement and that I understand and agree with it.*

**AUTHORITY FOR THE RELEASE OF INFORMATION:**

I understand and agree that REDiMED may contact and seek release of confidential information from my treating Doctor(s) referencing the nature of my health/injury conditions.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name) give my consent to REDiMED Total Injury Management, to contact and release any confidential medical information from my treating doctor(s) regarding that nature of my health condition(s).

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

*This signature confirms that I have read the above statement and that I understand and agree with it.*

**If you are currently, or have been treated for the applicable illness/injury, please indicate the clinic(s) details and treating doctor(s) below.**

**Medical Practice Information:**

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_

Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_