Rail Health Assessment Form
Category 1 (High Level Safety Critical Worker)

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 (February 2017) 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 completed by you (Section 3 of this form).

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 Compliance 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 <u>not permitted and will not treat any medical condition</u>, 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: EMPLOYEE/APPLICANT TO COMPLETE

1.1 Employee/Applicant Details		
Surname:	***First Names:***	
Depot/Location:	***Position:***	
Service Number:	***Date Of Birth:***	
1.2 Employer Details		
Supervisor/Contact:		
Date Medical Request :	***Phone:***	
Account to be sent to:		
Results to be sent to:	**/ Fax:**	
1.3 Health Assessment Appointment Details		
Health Professional:		
Address:		
Phone:	***Fax:***	
Appointment Date:	***Appointment Time:*** *(please arrive 15 mins prior)*	
Tests Required:	• **Fasting Cholesterol (Total and HDL)** • **Audiometry** • **Breath/Blood Alcohol Level**	• **Fasting Glucose** • **Resting ECG** • **Urine Drug Screening**
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: 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. 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 the CMO requires 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: ____ / ____ / 20_______

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)? **Yes** ☐ **No** ☐
   (Please take any medications with you to show the doctor) Please note brief details

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____

____

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

		Yes	No
3.1	High Blood Pressure	☐	☐
3.2	Heart Disease	☐	☐
3.3	Chest Pain, angina	☐	☐
3.4	Any condition requiring heart surgery	☐	☐
3.5	Palpitations/irregular heartbeat	☐	☐
3.6	Abnormal shortness of breath	☐	☐
3.7	Head injury, spinal injury	☐	☐
3.8	Seizures, fits convulsions, epilepsy	☐	☐
3.9	Blackouts or fainting	☐	☐
3.1	Migraine	☐	☐
3.11	Stroke	☐	☐
3.12	Dizziness, vertigo, problems with balance	☐	☐
3.13	Double vision, difficulty seeing	☐	☐
3.14	Colour blindness	☐	☐
3.15	Kidney disease?	☐	☐
3.16	Diabetes (please complete Part 8)	☐	☐
3.17	Neck, back or limb disorders	☐	☐
3.18	Hearing loss or deafness or had an ear operation or use a hearing aid	☐	☐
3.19	Do you have difficulty hearing people on the telephone (including use of hearing aid if worn)?	☐	☐
3.20	Have you ever had, or been told by a doctor that you have a psychiatric illness or nervous disorder?	☐ ☐	☐ ☐
3.21	Have you ever had any serious injury, illness, operation, or been in hospital for any reason	☐	☐

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?	☐	☐

If Yes? Where did you have the Test?______________________________

____

When did you have the Test?______________________________

4.2 Do you smoke of have been a smoker	☐	☐

If you are an ex-smoker when did you quit?______________________________

____

How much did/do you smoke?______________________________

4.3 Do you use illicit drugs?	☐	☐

If Yes, please state drugs used and frequency?______________________________

____

____

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?	☐	☐
5.2 Has anyone noticed that your breathing stops or is disrupted by episodes or choking during your sleep?	☐	☐

5.3 **Epworth Sleepiness Scale:**

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
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High change of dozing

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

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?	☐	☐	☐	☐	☐
7.2	In the past 4 weeks, about how often did you feel nervous?	☐	☐	☐	☐	☐
7.3	In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
7.4	In the past 4 weeks, about how often did you feel hopeless?	☐	☐	☐	☐	☐
7.5	In the past 4 weeks, about how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
7.6	In the past 4 weeks, about how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
7.7	In the past 4 weeks, about how often did you feel depressed?	☐	☐	☐	☐	☐
7.8	In the past 4 weeks, about how often did you feel that everything was an effort?	☐	☐	☐	☐	☐
7.9	In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
7.10	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)?

____

____

____

8. Clarke Hypoglycaemia Awareness Survey (Only complete if you are known Diabetic)

8.1 Tick the category that best describes you: (Tick one only)

☐ I always have symptoms when my blood sugar is low (A)
☐ I sometimes have symptoms when my blood sugar is low (R)
☐ I no longer have symptoms when my blood sugar is low (R)

8.2 Have you lost some of the symptoms that used to occur when your blood sugar was low?

☐ Yes (R)
☐ No (A)

8.3 In the past six months how often have you had sever hypoglycaemic episodes? (Episodes where you might feel confused, disorientated, or lethargic and were able to treat yourself)

☐ Never (A)
☐ Once or twice (R)
☐ Every other month (R)
☐ Once a month (R)
☐ More than once a month (R)

8.4 In the past year how often have you had sever hypoglycaemic episodes? (Episodes where you were unconscious or had a seizure and needed glucagon or intravenous glucose)

☐ Never (A)
☐ 1 to 11 time (R)
☐ 12 or more times (U)

8.5 How often in the last month have you had reading <3.8mmol/L with symptoms?

☐ Never
☐ 1 to 3 times
☐ 1 time/week
☐ 2-3 times/week
☐ 4-5 time/week
☐ Almost daily
(R = answers to 5 < answer to 6, A = answer to ≥ answer to 6)

8.6 How often in the last month have you had readings <3.8mmol/L without any symptoms

☐ Never
☐ 1 to 3 times
☐ 1 time/week
☐ 2-3 times/week
☐ 4-5 time/week
☐ Almost daily
(R = answers to 5 < answer to 6, A = answer to ≥ answer to 6)

8.7 How low does your blood sugar need to go before you feel symptoms?

☐ 3.3 – 3.8mmol/L (A)
☐ 2.7 – 3.3mmol/L (A)
☐ 2.2 – 2.7mmol/L (R)
☐ < 2.2mmol/L (R)

8.8 To what extent can you tell by your symptoms that your blood sugar is low?

☐ Never (R)
☐ Always (A)
☐Often (A)
☐Sometimes (R)
☐Rarely (R)

Scoring

- **Four or more "R" responses implies reduced awareness**
- **For Question 5 and 6, one "R" response is given if the answer to question 5 is less than the answer to question 6**
- **"A" response implies awareness**
- **"U" response (12 or more sever hypoglycaemic episodes in the last 12months) indicates unawareness**

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 employee/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 employees/applicants are required to present for fasting cholesterol (total and HDL), fasting glucose, blood alcohol and a resting ECG. Employees/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 employee/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
Age/sex		
Smoker Yes/No		
Blood Pressure (systolic)		
Fasting Cholesterol	-Total	
	-HDL	
	-Cholesterol Level	
HbA1c		
Cardiac Risk Level		

Other clinical considerations (refer section 18.2) Cardiovascular Conditions page 59 of Standard) eg symptoms, family and past history, co-morbidity, 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		

1.6 Resting ECG (Category 1 only) Normal ☐ Abnormal ☐

Notes:____

____

2. Diabetes

2.1 Is the person diabetic based on HbA1c? No ☐ Yes ☐

2.2 Is the person diabetic based on self report? No ☐ Yes ☐

If yes to the above,

2.3 Is the person diabetes satisfactorily controlled? No ☐ Yes ☐

2.4 Clarke Questionnaire, less than 4 'R" responses? No ☐ Yes ☐

Examining doctor to comment if No to either/ both of questions 2.3 and 2.4:

____

3. Neurological/Musculoskeletal:

3.1	**Cervical Spine rotation**	Normal	☐	Abnormal	☐
3.2	**Back movement**	Normal	☐	Abnormal	☐
3.3	**Upper Limbs**				
a)	Appearance	Normal	☐	Abnormal	☐
b)	Joint movements	Normal	☐	Abnormal	☐
3.4	**Lower Limbs**				
c)	Appearance	Normal	☐	Abnormal	☐
d)	Joint movements	Normal	☐	Abnormal	☐
3.5	**Gait**	Normal	☐	Abnormal	☐
3.6	**Is there any presence of tremor?**	No	☐	Yes	☐

3.7 **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 ☐

3.8 **Is a functional/practical assessment required?** Yes ☐ No ☐

4 Chest/Lungs:

Normal ☐ Abnormal ☐

5 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☐	

6 Vision:

6.1 **Visual Acuity Acceptable** **Better eye 6/9; Worse eye 6/18**

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

Are contact lenses worn? Yes ☐ No ☐

6.2 **Visual Fields** (Confrontation to each eye): Normal ☐ Abnormal ☐

6.3 **Colour Vision** Normal ☐ Abnormal ☐

(Ishihara: ≥ *3 errors/12 plates is a fail)*

If fail (as appropriate for task)

6.4 Fansworth D15 (Flat surface) Pass ☐ Fail ☐

6.5 LED Lantern test

6.5.1 3 metres Pass ☐ Fail ☐

6.5.2 6 metres Pass ☐ Fail ☐

7 Sleep:

7.1 **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*** ☐Temporarily unfit

7.2 **Body Mass Index (BMI)**

Weight ____________________kg

Height ____________________cm

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

☐If BMI is greater than 40 or greater than 35 with diabetes or high blood pressure refer for investigation

8 Substance Misuse

8.1 **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:			

8.2 **Drug Screen:**

____

____

	Negative	Positive	
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%

Psychological Health:

9.1 **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:			

9.2 Is attitude, speech and behaviour appropriate? No ☐ Yes ☐

10 Medications:

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

____

____

____

____

RELEVANT CLINICAL FINDINGS/RECOMMENDATIONS

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: / /20

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 employer 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 employer 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:**

____________________	____________________	Date: / /20
Name of Chief Medical Officer	Signature: Chief Medical Officer's records	