Name of rail transport operator:

Rail Safety Worker Health Assessment
Category 1 and 2

Worker Notification and Health Questionnaire

CONFIDENTIAL:
FOR PRIVACY REASONS THE COMPLETED FORM SHOULD BE RETAINED BY THE AUTHORISED HEALTH PROFESSIONAL AND NOT RETURNED TO THE RAIL TRANSPORT OPERATOR

Instructions to the worker / applicant

- You are required to attend a health assessment as part of your employment, to assess your fitness for rail safety work.
- The health assessment must be completed by *(date)* to ensure that you are able to carry out normal duties.
- Complete the enclosed questionnaire **before attending the appointment** and provide it to the examining doctor. **The last page of the questionnaire must be signed by you in the presence of the examining doctor.**
- Please take to the appointment:
  - glasses, hearing aid or any other aids required for conduct of your work;
  - all medication that you are currently taking or a list of such medications; and
  - photo identification
- If you are a **Category 1 Safety Critical Worker** you will be required to have a blood test as part of your assessment. To get a true reading of your cholesterol (total and HDL) you must not eat for a minimum of 8 hours (and no longer than 14 hours) before your blood test. You may drink water but you should not have sweetened drinks or juice. This appointment/test should take place at least 48 hours before the appointment with the doctor so that he/she has the results.

What happens if the examining doctor suspects there is a health problem?

If the examining doctor finds or suspects something is wrong with your health that you did not know about, they will ask your permission to inform your own doctor. The examining doctor will not treat any medical condition but will give you a letter to take to your own doctor.

If the doctor finds that you do not meet all relevant medical criteria, your supervisor at the rail transport operator will discuss with you the appropriate actions to be taken. This may include:

- modification of the duties that you undertake for the rail transport operator; and/or
- scheduling of a further review, tests of specialist referral.

Disclosure of health information – please read carefully and sign to indicate you understand how health information is reported, stored and accessed.

All your detailed medical papers including your questionnaire responses, test results and the complete record of clinical findings are kept confidential, and are not available to your managers. The examining doctor sends only the completed report form directly to the rail transport operator indicating your fitness or otherwise for duty.

If the rail transport operator uses the services of a Chief Medical Officer (CMO), the CMO may access a copy of your health record to aid in the management of your health in relation to your work or for audit purposes or to compile statistics. The CMO must maintain the confidentiality of these records and ensure that your personal information is not made available to, or discussed with, any other person within the organisation.

Other than the above, your personal information will not be disclosed to any other person or organisation without your written permission, except:

- when the rail transport operator appoints a health professional to conduct an audit of the system for the health assessment of rail safety workers, then the appointed health professional will have access to the information for the purpose of undertaking the audit; and
- where required by law.

You have the right to access your health records including those held by the Authorised Health Professional and the reports held by the rail transport operator.

Worker's declaration

I, *(print name)*

certify that I have read and understood the above statement concerning the health information provided in this document.

Signature: Date:

PART A – Rail transport operator to complete

Date of request:	

Worker / Applicant details

Family name:	First names:
Employee no:	Date of birth:

Risk Category: ☐ Category 1 ☐ Category 2

Health assessment appointment details

Doctor / practice:	
Address:	Phone:
Appointment date:	Time:

PART B – Health Questionnaire – Worker / Applicant to complete

This questionnaire must be completed in order to help assess your fitness for rail safety duties. 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.

		Doctor comments
1.	Are you currently attending a health professional for any illness or injury? ☐ No ☐ Yes	

2.	**Do you suffer from or have you ever suffered from:**	**Doctor comments**
High blood pressure	☐ No ☐ Yes	
Heart disease	☐ No ☐ Yes	
Chest pain, angina	☐ No ☐ Yes	
Any condition requiring heart surgery	☐ No ☐ Yes	
Abnormal shortness of breath or chest disease	☐ No ☐ Yes	
Palpitations / irregular heartbeat	☐ No ☐ Yes	
Head injury, spinal injury	☐ No ☐ Yes	
Seizures, fits, convulsions, epilepsy	☐ No ☐ Yes	
Blackouts or fainting	☐ No ☐ Yes	
Stroke	☐ No ☐ Yes	
Dizziness, vertigo, problems with balance	☐ No ☐ Yes	
Double vision, difficulty seeing, or difficulty adapting to changing light conditions	☐ No ☐ Yes	
Colour blindness	☐ No ☐ Yes	
Memory loss or difficulty with attention or concentration	☐ No ☐ Yes	
Diabetes	☐ No ☐ Yes	

PART B (continued)

2. Do you suffer from or have you ever suffered from:		Doctor comments
Neck, back or limb disorders	☐ No ☐ Yes	
Hearing loss or deafness or had an ear operation or use a hearing aid	☐ No ☐ Yes	
A psychiatric illness or nervous disorder	☐ No ☐ Yes	

			Doctor comments
3.	Have you ever had any other serious injury, illness, operation, or been in hospital for any reason? Please describe briefly below.	☐ No ☐ Yes	

4. The following questions relate to your intake of alcohol. Please circle the answer that is correct for you:

		(0)	(1)	(2)	(3)	(4)
4.1	How often do you have a drink containing alcohol?	☐ Never (go to Q5)	☐ Monthly or less	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
4.2	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
4.3	How often do you have six or more drinks on one occasion?	☐ Never	☐ Monthly or less	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
4.4	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	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
4.5	How often during the last year have you failed to do what was normally expected from you because of drinking?	☐ Never	☐ Monthly or less	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
4.6	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	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
4.7	How often during the last year have you had a feeling of guilt or remorse after drinking?	☐ Never	☐ Monthly or less	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
4.8	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	☐ 2 to 4 times per month	☐ 2 to 3 times per week	☐ 4 or more times per week
4.9	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
4.10	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

Doctor comments

5. The following questions are about your sleeping patterns:		Doctor comments
5.1	Have you ever been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy? ☐ No ☐ Yes	
5.2	Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep? ☐ No ☐ Yes	

Please use the following scale (Epworth Sleepiness Scale) to choose the most appropriate description for each situation. The questions refer 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.

5.3 How likely are you to doze off or fall asleep (rather than just feeling tired) in the following situations:	would never doze off **(0)**	slight chance of dozing **(1)**	moderate chance of dozing **(2)**	high chance of dozing **(3)**
• Sitting and reading	☐	☐	☐	☐
• Watching TV	☐	☐	☐	☐
• Sitting inactive in a public place (e.g. a theatre or a meeting)	☐	☐	☐	☐
• As a passenger in a car for an hour without a break	☐	☐	☐	☐
• Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
• Sitting and talking to someone	☐	☐	☐	☐
• Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
• In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐

Doctor comments

6. Do you smoke or have you ever been a smoker?	
☐ No	
☐ Ex-smoker	Quit date:
☐ Yes	Number of cigarettes per day:

Doctor comments

7. Do you use illicit drugs?	☐ No ☐ Yes

Doctor comments

PART B (continued)

8. The following questions relate to how you are feeling. Please tick the answer that is correct for you:

In the past 4 weeks about how often did you:	None of the time **(1)**	A little of the time **(2)**	Some of the time **(3)**	Most of the time **(4)**	All of the time **(5)**
• Feel tired out for no good reason?	☐	☐	☐	☐	☐
• Feel nervous?	☐	☐	☐	☐	☐
• Feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
• Feel hopeless?	☐	☐	☐	☐	☐
• Feel restless or fidgety?	☐	☐	☐	☐	☐
• Feel so restless you could not sit still?	☐	☐	☐	☐	☐
• Feel depressed?	☐	☐	☐	☐	☐
• Feel that everything was an effort?	☐	☐	☐	☐	☐
• Feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
• Feel worthless?	☐	☐	☐	☐	☐
Doctor comments					

PART C – For existing employees only

		Doctor comments
9.	Have you experienced difficulty completing any tasks required for your work (e.g. walking on ballasts, hearing train instructions)? If yes, please describe:	☐ No ☐ Yes
10.	Have you been involved in any accidents or near misses at work in the period since your last assessment? If yes, please describe:	☐ No ☐ Yes

PART D – Worker's declaration

(To be completed by the worker in the presence of the health professional after completing the questionnaire)

I, *(print name)*

certify that to the best of my knowledge the information provided by me is true and correct.

Signature of worker:

Signature of doctor:

Date: