TAS WORKHEALTH

OCCUPATIONAL HEALTH
REHABILITATION
AND
INJURY MANAGEMENT
SERVICES

Dr. John O'Sullivan & Associates

All correspondence to:

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PRE-EMPLOYMENT MEDICAL

Applicant Details

FULL NAME: _____

ADDRESS: _____

HOME PHONE: _____ MOBILE PHONE: _____

DATE OF BIRTH: _____ MALE FEMALE

POSITION APPLIED FOR: _____

MEDICAL HISTORY – Have you ever experienced or seen a doctor or therapist for any of the following conditions:

YES/NO	Lung Problems/Bronchitis
YES/NO	Asthma
YES/NO	Blood Pressure/Heart Problems/Circulatory Disorders
YES/NO	Anxiety/Depression/Psychiatric conditions of any kind
YES/NO	Persistent headaches/Migraines
YES/NO	Fits/Seizures/Blackouts
YES/NO	Stomach Problems/Ulcers
YES/NO	Repetitive Strain/Over Use conditions
YES/NO	Arthritis/Rheumatism
YES/NO	Joints – Pain/Problems/Fractures
YES/NO	Back or Neck Pain/Discomfort/Stiffness
YES/NO	Hepatitis/Jaundice/Liver Trouble
YES/NO	Hernia
YES/NO	Loss of Hearing
YES/NO	Visual (Eyesight) Impairments
YES/NO	Diabetes
YES/NO	Skin Disorders/Dermatitis/Skin Cancers

YES/NO Have you had any illness or suffered any breakdown, met with any injury or wound or undergone any surgical operation not already stated above?
YES/NO Have you ever had any surgery?
YES/NO Have you ever been admitted to hospital?
YES/NO Have you had cancer?

If YES to any of the above, please provide details including relevant dates:

_____
_____
_____

Please answer the following questions:

Have you ever been in hospital?
YES/NO
Specify if YES _____

Have you seen a doctor in the last 6 months?
YES/NO
Specify if YES _____

In what year was your last Tetanus injection:_____

Are you currently taking any regular or non-regular medication, including over the counter (non-prescribed) medication?
YES/NO
Specify if YES _____

Have you had any injury or medical condition that prevented or restricted you from working in your usual occupation?
YES/NO
Specify if YES _____

PHYSICAL ABILITIES:

Do you have, or have you ever had difficulty with any of the following:
YES/NO Working at heights
YES/NO Wearing Personal Protective Equipment (PPE)
YES/NO Lifting more than 20kg
YES/NO Repetitive movements of the hands or arms
YES/NO Shift work
YES/NO Confined spaces
YES/NO Reading ordinary newsprint
YES/NO Concentration

YES/NO Understanding written English
YES/NO Understanding verbal English
YES/NO Bending repetitively
YES/NO Hearing in a normal conversation
YES/NO Crouching
YES/NO Kneeling

Comments:_____
_____
_____

Have you experienced any of the following?

YES/NO Breathlessness or difficulty in breathing when walking briskly or climbing stairs
YES/NO Frequent cough
YES/NO Bringing up phlegm
YES/NO Wheezing or whistling in your chest
YES/NO Cough, breathlessness or sneezing due to dust, fumes or gases
YES/NO Fainting/light headedness
YES/NO Loss of balance
YES/NO Hearing loss
YES/NO Ringing in the ears
YES/NO Back/Neck pain
YES/NO Stiffness or aching in back, neck, shoulder, elbow, wrist, hip, knee or ankle
YES/NO Weakness in arms or legs
YES/NO Pain when doing exercise
YES/NO Unexplained loss of weight

Comments:
_____
_____
_____

HEALTH QUESTIONNAIRES:

Have you ever had or been told by a doctor that you have a sleep disorder, sleep apnoea or narcolepsy?
YES/NO
Specify if YES _____

Has anyone noticed that your breathing stops or is disrupted by choking during your sleep?
YES/NO
Specify if YES _____

Epworth Sleepiness Scale:

The following questions refer to sleepiness or the tendency to doze off when relaxed.
How likely are you to doze or fall asleep in the following situations, in contrast to just feeling tired? This refers to the usual way of life in recent times. Even if you have not done some things recently, try to work out how they would have affected you. Use the scale shown to choose the most appropriate number for each situation.

	0 Would never doze	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing
Sitting and reading				
Watching TV				
Sitting inactive in a public place e.g. theatre, 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 lunch without alcohol				
In a car stopping for a few minutes in traffic				

K10 Questionnaire:

Please tick the answer that is correct for you.

In the past 4 weeks about how often did you feel:	5 All the time	4 Most of the time	3 Some of the time	2 A little of the time	1 None of the time
Tired out for no good reason					
Nervous					
So nervous that nothing could calm you down					
Hopeless					
Restless or fidgety					
So restless you could not sit still					
Depressed					
So sad that nothing could cheer you up					
Worthless					

Audit Questionnaire:

Please tick the answer that is correct for you.

	0 Never	1 Monthly or less	2 2-4 times per week	3 2-3 times per week	4 4 times or more a week
How often do you have a drink containing alcohol?					
How many drinks containing alcohol do you have on a typical day when you are drinking? PLEASE CIRCLE	1-2	3-4	5-6	7-9	10 or more
How often do you have six or more drinks on one occasion?					

	0 Never	1 Monthly or less	2 2-4 times per week	3 2-3 times per week	4 4 times or more a week
How often during the past year have you found that you were not able to stop drinking once you had started?					
How often during the past year have you failed to do what was normally expected of you because of drinking?					
How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?					
How often during the past year have you had a feeling of guilt or remorse after drinking?					
How often during the past year have you been unable to remember what happened the night before because you had been drinking?					
Have you or has someone else been injured as a result of your drinking?					
Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?					

Lifestyle History:

	Yes	No	Comments
Do you smoke or have you ever been a smoker?			
If you smoke now, how many cigarettes do you smoke per day?			
Do you use or smoke marijuana?			
Do you use any recreational drugs?			
Do you undertake any regular exercise?			

Notes:

- Various State Workers' Compensation Acts provide for a penalty or rejection of a claim where false or misleading information has been given in relation to answering questions on current and past medical conditions upon seeking employment.
- Failure to answer all questions fully may invalidate the pre selection process and result in your application for employment being disregarded.
- All medical information collected shall be held in strict confidence and in accordance with Privacy legislation.

Declaration and Authority to Release Medical Information

I hereby certify that to the best of my knowledge and belief the answers given by me are true and correct and I have read and understood the Notes shown above. Authority is given by me to Dr. John O'Sullivan or another TWH doctor to make any enquiries as may be considered necessary to accurately establish my medical history and fitness for work in the position I have applied for, and to make disclosure of any relevant assessment to the prospective employer.

Signed: _____ Name: _____

Date: _____

MEDICAL EXAMINATION TO BE COMPLETED BY DOCTOR

Height _____cms

Weight _____ kgs.

BMI _____% Slight/Average/Muscular/Obese

Blood Pressure Systolic _____ Diastolic _____

Pulse Rate _____/min Rhythm _____

Comments: _____

VISION:

	Distant (Snellen Chart at 6m)	
	Uncorrected	Corrected
Right Eye	6/	6/
Left Eye	6/	6/
Both	6/	6/
	Near (Times Roman Chart at 30cm and 1m)	
	Uncorrected	Corrected
Right Eye	N	N
Left Eye	N	N
Both	N	N

Colour Vision:

Number of Plates Correct _____/24

Colour Vision Normal? YES/NO

Comments of Colour Vision _____

URINALYSIS:_____

HEARING:
Results of Audiological Testing attached? YES/NO
Is there any evidence that hearing is impaired to an extent that personal safety is compromised? YES/NO
Comments on hearing _____

RESPIRATORY:

Spirometry -

	Actual	Predicted	% Predicted
FEV1			
FVC			
FEV1/FVC			

URINE DRUG & ALCOHOL SCREEN:

	Negative	Positive
Instant	☐	☐
Laboratory	☐	☐

MEDICAL EXAMINATION:

GENERAL:	Yes	No	Comments
Are there any marks, scars or developmental abnormalities?			
Is there any evidence of severe skin or nail disease?			
Is there evidence of drug or alcohol intoxication or addiction?			
Is there evidence of current medication use? If so, does this affect the ability to safely perform their job description including reaction time in an emergency?			
VISION:	**Yes**	**No**	**Comments**
Are glasses or contact lenses worn?			
Is peripheral vision normal using the clinical finger confrontation test?			
Are the pupils equal and reactive?			
Is fundoscopy normal? (if clinically indicated)			
Is visual correction required at all times to maintain the minimum standard of visual acuity?			
Is the minimum standard for visual acuity met?			
Is colour vision normal? (note more than 2 errors is a fail)			
HEARING:	**Yes**	**No**	**Comments**
Does the applicant meet the minimum criteria for an air conduction audiogram?			
MUSCULOSKELETAL:	**Yes**	**No**	**Comments**
Is there a full unrestricted range of movement in:-			
Cervical and Thoracic Spine			
Lumbar Spine			
Shoulders/Upper Limbs			
Elbows			
Wrists			
Fingers/Thumbs			
Hips			
Knees/Lower Limbs			
Ankles			
Toes			

Is there any evidence of disorder, degeneration or injury to the following:-	Yes	No	Comments
Cervical and Thoracic Spine			
Lumbar Spine			
Shoulders/Upper Limbs			
Elbows			
Wrists			
Fingers/Thumbs			
Hips			
Knees/Lower Limbs			
Ankles			
Toes			
Is gait abnormal?			
Is there ankylosis, amputation or absence of a limb (whole or part)?			
Full Squat			
Duck Walk			
Heel to Toe			
Walk on Toes			
Walk on Heels			
RESPIRATORY:	**Yes**	**No**	**Comments**
Is there any irregularity in breathing?			
Is there any abnormality of the chest wall?			
Is there any abnormality on examination?			
Are there any signs of past or present respiratory disease including thoracotomy?			
Is there any abnormality in the spirometry reading? (if requested)			
Is further investigation required? (specify)			
GASTROINTESTINAL SYSTEM:	**Yes**	**No**	**Comments**
Is there any abdominal tenderness?			
Is there a hernia present?			
Is there lymphadenopathy?			
Is there any evidence of abdominal mass?			
Is further investigation required? (specify)			
NEUROLOGICAL SYSTEM:	**Yes**	**No**	**Comments**
Is there any abnormality of the CNS?			
Is there any abnormality of the peripheral nervous system?			

NEUROLOGICAL SYSTEM continued:	Yes	No	Comments
Is there any abnormality with balance? (Rhomberg's test)			
Is there any evidence of cerebellar dysfunction or impaired co-ordination?			
Is there evidence of dementia or other cognitive impairments, including head injury or neglect?			
Is there evidence of neuromuscular conditions including multiple sclerosis, parkinsonism or peripheral neuropathy?			
METABOLIC AND ENDOCRINE SYSTEM:	**Yes**	**No**	**Comments**
Is there evidence of other metabolic or endocrine abnormalities? Cushing's, Addison's, thyroid or pituitary disease, diabetes?			
PSYCHIATRIC:	**Yes**	**No**	**Comments**
Is there any evidence of a psychiatric condition that requires medication or poses a risk to the personal safety of the candidate or others?			
Is there evidence of impaired judgement or perceptual, cognitive or motor dysfunction?			
CARDIOVASCULAR:	**Yes**	**No**	**Comments**
Is there any abnormality in heart sounds or rhythm?			
Are any peripheral pulses absent?			
Is there evidence of angina, myocardial infarction, angioplasty or other cardiovascular conditions?			
Is there any evidence of cardiac failure?			
Is there any abnormality of the venous system?			
Is there any evidence of cardiovascular related surgery?			
Is there evidence of an implanted cardiac pacemaker or defibrillator?			
Is there evidence of anticoagulation therapy?			

CARDIOVASCULAR continued:	Yes	No	Comments
Is there evidence of congenital heart disease?			
Are further investigations required? (please specify)			
SLEEP: – Calculate Epworth Scale /24	**Yes**	**No**	**Comments**
Is score 16 or greater?			
If so is further action required? (please detail)			
Is score between 11 & 15 with other risk factors present?			
If so is further action required? (please detail)			
ALCOHOL: – Calculate Audit Score /40	**Yes**	**No**	**Comments**
Is score 8 or greater?			
If so is further action required? (please detail)			
Are there other clinical findings, which warrant further investigation? (please detail)			
PSYCHOLOGICAL HEALTH (K10):	**Yes**	**No**	**Comments**
Is there any evidence of anxiety/depression?			
Is there any evidence of past or current psychotic illness or episode?			
Is further assessment required? (please detail)			
Calculate K10 Questionnaire /50	**Yes**	**No**	**Comments**
Is score 19 or greater?			
If so is further action required? (please detail)			
JOB SPECIFIC CONSIDERATIONS:	**Yes**	**No**	**Comments**
Are there any physical or medical restrictions that would impact the following job requirements -			
The manual handling requirements of the position?			

JOB SPECIFIC CONSIDERATIONS continued:	Yes	No	Comments
Sustaining postures such as crouching, squatting and kneeling for long periods?			
Shift work (up to 12 hour shifts Day/Night)?			
Communicating clearly in spoken and written English?			
Operating a commercial/heavy vehicle?			
Other (please specify)?			

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PRE-EMPLOYMENT MEDICAL SUMMARY

Name: _____ was assessed on _____

for the position of _____

Based on the above examination, I am of the opinion that the above mentioned person is:-

☐ Fit for proposed employment.

☐ Fit for proposed employment, but not other positions without further medical review – please explain below.

☐ Unfit for proposed employment but may be fit for other positions – please explain below.

☐ Unfit for any position – please explain below.

☐ Further information is required before an opinion on the suitability for the proposed position can be made – please explain below.

Comments:

Signed: _____ Date: _____
Doctor's Name: _____
Surgery/Clinic Name: _____
Address: _____
_____