The Health Alliance @ Brigstock

Medical Practice

**Occupational health assessment – Pre placement questionnaire**

*This form contains confidential medical information which will only be shared with the Occupational Health Practitioner.*

The purpose of this health assessment is to ensure, so far as is possible, that you are fit for the activities you will be undertaking in order to protect your own and others’ health and safety.

Questions are asked about your past and present health, medical treatment and any impairment which may have implications for health and safety.

**Please ensure all sections are completed in full and if not applicable or not known please state this and do not just leave blank. Failure to complete all sections could result in a delay in the processing of your form – thank you.**

**Please return to:**

# marked private and confidential to Dipti Gandhi, Clinical Lead, The Health Alliance Brigstock Medical Practice, 141 Brigstock Road, Thornton Heath, CR7 7JN **or via email dgandhi@nhs.net**

|  |  |
| --- | --- |
| Surname: | Prof[ ]  Dr[ ]  Mr[ ]  Mrs[ ]  Miss [ ]  Ms[ ]  Other[ ]  |
| Forename(s):  |
| Address: |
| Tel: Mobile: Email:  |
| Date of birth:  | Gender: Male [ ]  Female [ ]  |

**BRIEF DESCRIPTION ACTIVITIES:**

(This will enable our occupational health practitioner to assess the health risk involved with your work)

|  |
| --- |
| 1. **Job Title:**
2. Description of role or please provide a job description
 |
| 1. **Name of Company and Line Manager you have been offered a post with:**
2. **Location(s) of work**:
 |
| 1. Hours of work – full time or part time
2. Shift work – please detail
 | Number of hours per week:  |
| 1. The job involves:
 |
| * Direct contact with public?
 | Yes [ ]  No [ ]  |
| * Direct contact with children?
 | Yes [ ]  No [ ]  |
| * Do you work with machinery on a daily basis?
 | Yes [ ]  No [ ]  |
| * Regular Driving (please state type of vehicle and licence) ie PSV/LGV
 | Yes [ ]  No [ ]  |
| * Regular clinical contact with patients/service users and direct involvement in patient care?
 | Yes [ ]  No [ ]  |
| * Non-clinical social contact with patients/service users but not directly involved in patient care (e.g. focus groups/certain interview studies)?
 | Yes [ ]  No [ ]  |
| * Working in a laboratory/mortuary and handling pathogens or potentially infected specimens?
 | Yes [ ]  No [ ]  |
| * Working with specimens containing specific organisms (e.g. typhoid, smallpox etc)?
 | Yes [ ]  No [ ]  |
| * If YES, provide details of the organisms here:
 |
| * Please list here any other duties or specialist equipment used as part of your role:
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**VACCINATION HISTORY**

Please give details of vaccinations and tests you have had. Where possible, give dates and results. If not known please state unknown, or if you have not any of the vaccinations listed below, please just write No.

|  |
| --- |
| **Immunisation History** |
| 1a | MMR vaccination  | Dates:  |
| 1b | Measles, mumps and rubella blood test | Date:  |
| Result:  |
| 2a | Hepatitis B vaccinations | Date: (1)  |
| Date: (2)  |
| Date: (3) |
| 2b | Hepatitis B booster | Date:  |
| 2c | Hepatitis B antibody screening | Date:  |
| Result:  |
| 3a | Heaf, Mantoux or Tine test (TB test) | Date:  |
| 3b | BCG (TB vaccination) | Date:  |
| 4 | Polio booster | Date:  |
| 5 | Tetanus booster | Date:  |
| 6 | Have you had chicken pox? | Yes [ ]  No [ ]  Unsure [ ]  |
| 6a | Varicella (chickenpox) blood test | Date:  |
| Result: |
|  | Varicella immunisations | Dates: 1st 2nd |
| 7 | Covid 19 | Dates 1st: 2nd Booster  |
| 8 | Other |  |

**DECLARATION OF HEALTH**

|  |  |
| --- | --- |
| 1. Do you currently have any health problems, including psychological problems, or are you awaiting surgery? | Yes [ ]  No [ ]  |
| 2. Are you presently receiving any prescribed medication, treatment or therapy except contraception? | Yes [ ]  No [ ]  |
| 3. How many days off sick have you had over the past two years? |  |
| 4. Do you have any health or psychological condition that may affect your ability to perform the proposed role? | Yes [ ]  No [ ]  |
| 5. Do you have any health condition caused or made worse by work? | Yes [ ]  No [ ]  |
| 6. Do you have any disability or other health condition not mentioned above that may require additional help or support to perform the duties outlined in the job description for this role? | Yes [ ]  No [ ]  |

If you have answered ‘yes’ to any of the above, please give details, below, including dates and how it affects you now. Continue on a separate sheet if necessary.

|  |  |
| --- | --- |
| Question | Further details |
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|       |       |
|       |       |
|       |       |

Name and address of GP

Telephone Number:

**DECLARATION**

The information in this form is true and complete. I agree that any deliberate omission, falsification or misrepresentation in the form may be grounds for rejecting this application and/or subsequent disciplinary action, including dismissal.

I consent to relevant health information about me being shared between the occupational health practitioner of my employer. I hereby agree to inform the occupational health practitioner of my employer of any changes in my health circumstances that may affect my ability to perform the role.

I understand the importance of routine infection-control procedures, including the importance of hand hygiene, health & safety and appropriate use of protective clothing and compliance with local policies.

|  |  |
| --- | --- |
| Signed: | Date:  |