Sonic HealthPlus

QueenslandRail

Medical Assessment Rail Category 1
High Level Safety Critical Worker

Name:
Service Number

AssessmentType
Date:

PART ONE	Photo ID Sighted ☐ Yes ☐ No	Employee Service Number:	Service Number
Section 1: Your personal Details			
Surname		First Name	
Address			Post Code
Home Phone		Mobile Phone	
Date of Birth		Gender	☐ Male ☐ Female
Proposed Role			

Section 2: 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.

	No	Yes	Doctor Comments
1. re you currently attending a health professional for any illness and injury?	☐	☐	
2.			Do you suffer from or have you ever suffered from :
High blood pressure	☐	☐	
Heart Disease	☐	☐	
Chest pain, angina	☐	☐	
Any condition requiring heart surgery	☐	☐	
Abnormal shortness of breath or chest disease	☐	☐	
Palpitations/irregular heart beat	☐	☐	
Head injury, spinal injury	☐	☐	
Seizures, fits, convulsions, epilepsy	☐	☐	
Blackouts or fainting	☐	☐	
Stroke	☐	☐	
Dizziness, vertigo, problems with balance	☐	☐	
Double vision, difficulty seeing, or difficulty and adapting to changing light conditions	☐	☐	
Colour blindness	☐	☐	
Memory loss or difficulty with attention or concentration	☐	☐	
Diabetes	☐	☐	
Neck, back or limb disorders	☐	☐	
Hearing loss or deafness or had an ear operation or use a hearing aid?	☐	☐	
A psychiatric illness or nervous disorder	☐	☐	

3. ave you ever had any other serious injury, illness, operation, or been in hospital for any reason? Please describe briefly	☐ No ☐ Yes Describe:

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:	

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Part C: For existing employees only		Doctor Comments
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	
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	

Worker's declaration

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

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

Signature of Worker _____ Signature of doctor_____ Date: 28 **August 2017**

Patient consent

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

I, ☐ Give ☐ Do not give

Permission for the examining health professional to contact my doctor(s) to discuss or clarify information relating to my current health status.

The HP may have a verbal discussion with my Doctors if I am present with the HP or my Doctor. If I am unable to be present, communication between the HP and my Doctors must be in writing.

Signature of worker _____

(1) Name of doctor _____ (2) Name of doctor _____

Phone _____ Phone _____