Department of Infrastructure

Code of Practice for Health Assessment of Rail Safety Workers

Model Forms

The following model forms support the consistent application of the Code of Practice and should not be modified other than to incorporate particular administrate requirements of rail organisations.

NOTE: The forms are colour coded for ease of administration.

July 2004

1. Safety Critical Worker Health Assessment

1.1 Request and Report Form

The Request and Report form (Blue Form) is the key means of communication between the rail organisation and the Authorised Health Professional.

The form is used as follows:

1. ***Part A:*** The employer completes PART A, encloses copies of relevant supporting information (eg. previous Health Assessment Report, sick leave summary, relevant worker's compensation reports or critical incident reports) and a copy of the Health Professional Record (Form 1.3), and forwards them to the Authorised Health Professional.
2. ***Part B:*** Upon completion of the assessment, the health professional completes PART B of the form, retains a copy and returns the original form to the employer.
3. ***Part C:*** The employer completes PART C of the form to indicate the action taken as a result of the assessment.
4. ***Part D:*** The worker/applicant completes PART D of the form to indicate agreement to the portability of the Health Assessment Record.

THE COMPLETED FORM SHOULD BE RETURNED TO THE RAIL ORGANISATION
A COPY SHOULD BE RETAINED BY THE AUTHORISED HEALTH PROFESSIONAL

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Safety Critical Worker Health Assessment
REQUEST AND REPORT FORM
(BLUE FORM)

IMPORTANT INFORMATION

To the Employer

- Please complete all relevant details in PART A of the form including:
  - Personal details of the worker/applicant.
  - Appointment details.
  - A description of the rail safety duties to be performed by the worker/applicant (or attach Job Description or Task Risk Assessment).
  - The Risk Category determined by the tasks and therefore the level of assessment (Category 1 or 2).
  - The type of assessment requested (eg. Pre-placement, Change of Risk Category, Periodic, Triggered).
  - The pathology tests required (High Level Safety Critical Worker only).
  - Audiometry requirements.
- Additional forms and information to be issued with this request include:
  - Health Assessment Record (Green Form) to be completed and retained by the Authorised Health Professional.
  - Screen–based Equipment Request and Report Form and Assessment Record (if required).
  - Any additional information relevant to the assessment including copies of previous Health Assessment Report, relevant workers' compensation reports, critical incident history and sick leave record.
- On receipt of the completed Health Assessment Report:
  - Complete PART C and take action as appropriate.
  - Ask the worker/applicant to complete and sign PART D as required in order to give permission for the report to be forwarded to another rail organisation.

To the Health Professional

- You are requested to conduct a health assessment to assess the worker's fitness for rail safety duties according to the details provided in PART A of this form and according to Volume 2 of the *Code of Practice for Health Assessment of Rail Safety Workers*.
- You must sight photo identification of the worker/applicant (eg Rail Safety Worker's Card, driver's licence).
- Please perform the assessment, complete PART B of this form and return to the worker's employer according to instructions noted in PART A, within 7 days of the assessment, OR should the worker be assessed Unfit for Duty, please contact the employer immediately by phone so that appropriate rostering changes may be made.
- Category 1 High Level Safety Critical Workers are required to present for fasting cholesterol (total and HDL), fasting glucose and an ECG for Pre-placement, Change of Risk Category and Periodic Health Assessments. Results will be forwarded to you directly.
- Both Category 1 and Category 2 Safety Critical Workers are required to have audiometry for Pre-placement, Change of Risk Category and Periodic Health Assessments. This will be arranged separately if audiometry facilities are not available at your practice.
- You may need to contact the worker's/applicant's nominated doctor to discuss conditions that may affect their fitness for rail safety work. Such contact should be made with the worker's signed consent (provision for this is included on the Green Form).
- Details of the examination should be recorded on the enclosed Health Assessment Record (Green Form). This record is confidential and should be retained by you, not returned to the employer. The employer's Chief Medical Officer (if they have one) may contact you for more information regarding the worker's condition.
- For more detailed information about the conduct of health assessments for rail safety workers see Volume 2 of the *Code of Practice for Health Assessment of Rail Safety Workers*.

PART A – Employer to complete

1. Worker/Applicant Details	
Family Name:	***First Names:***
Company:	
Location:	
Employee No:	***Date of birth:***

2. Rail Organisation Details		
Supervisor/contact:		
Date of request:	***Phone:***	***Facsimile:***
Account and report to be sent to Supervisor at the following address (Please insert postal address or fax number):		

3. Health Assessment Appointment Details:	
Doctor/Practice:	
Address:	
Phone:	***Facsimile:***
Appointment Date:	***Time:***

4. Description of Duties (or see attached Job Description or Task Risk Assessment):

5. Supporting information relevant to the assessment *(tick information provided)*:

- [ ] Previous relevant Health Assessment Report(s)
- [ ] Relevant sick leave for last 12 months (number of days, not details):
  ____
- [ ] Relevant Workcover history
- [ ] Relevant Critical Incident episodes
- [ ] Positive Drug and Alcohol Assessment Reports
- [ ] Record of involvement in serious rail safety incidents
- [ ] Other (specify): ______________________________

____
____
____
____
____
____
____

6. Type of Assessment required:

- [ ] Pre-placement / Change of Risk Category Health Assessment
- [ ] Periodic Health Assessment
- [ ] Triggered Health Assessment (specify reason):
  ____
- [ ] Drug Screen
- [ ] Screen-Based Equipment Examination
- [ ] Other (specify):
  ____

7. Risk Category/Level of Assessment:

- [ ] Category 1 (High Level Safety Critical Worker)
- [ ] Category 2 (Safety Critical Worker)

Specific Health Requirements:

Colour vision
- [ ] Normal
- [ ] Colour Defective Safe A
- [ ] Colour Defective Safe B (SBE)

Hearing
- [ ] Driver
- [ ] Non Driver / Other

Musculoskeletal (note specific requirements):
____
____
____

8. Tests Ordered:

<u>**Cardiac Risk Assessment (Category 1 only)**</u>

- [ ] Fasting Cholesterol (total and HDL)
- [ ] Fasting Plasma Glucose
- [ ] Resting ECG
- [ ] **Drug Screen**

Pathology ordered from: ______________________________

- [ ] **Audiometry (Category 1 and 2)**

Audiometry ordered from: ______________________________

Worker/Applicant Name:		
Employee No.	***Date of birth:***	***Date of Request:***

PART B – Health Professional to complete

☐ **I have sighted the worker's Rail Safety Worker Card** **Number______________________________ OR**

☐ **I have sighted the worker's/applicant's photo ID (eg driver's licence, passport) Number______________________________**

I certify that I have examined the worker/applicant named in accordance with the medical standards contained in the *Code of Practice for Health Assessment of Rail Safety Workers, Volume 2: Assessment Procedures and Medical Criteria* and in my opinion the worker/applicant is *(tick appropriate box)*:

☐ **Fit for Duty –** Meets all relevant medical criteria.	☐ Local doctor referral ☐ Conditional on corrective lenses ☐ Conditional on hearing aid ☐ Other condition (specify): ________________________ ____ ____
☐ **Fit for Duty Subject to Review** – Does not meet all medical criteria, but could perform current rail safety work if the condition is sufficiently under control and worker is more frequently reviewed than prescribed under periodic review.	**I recommend:** ☐ Review at this practice DATE: ☐ ☐ 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 current rail safety work if suitable modifications were made.	**I recommend the following job modifications:** ____ ____ ____
☐ **Temporarily Unfit for Duty Subject to Review** – Does not meet all medical criteria and cannot perform current rail safety tasks but may perform alternative tasks. May return to full duty pending improvement in condition, response to treatment, confirmed diagnosis of undifferentiated illness.	**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.	**I recommend the following in terms of management and review:** ____ ____ ____

Drug Screen Results (if required):

Health Professional Details (stamp acceptable):		
Name:	***Phone:***	***Facsimile:***
Practice address:		
Signature:	***Date of Assessment:***	

PART C – Employer to complete on receipt of Assessment Report

Action taken as a result of Health Assessment:

☐ Job modification (details):____

☐ Triggered review (indicate period): ________________________________

☐ Periodic Health Assessment scheduled (details): ______________________

☐ Redeployment (details): ____

☐ Drug Assessment (details): _______________________________________

PART D – Worker to complete regarding portability of assessment result

I, ____ (Print Name) give permission for this health assessment to be forwarded to another rail organisation as confirmation of fitness for duty.

Signature: ______________________________ Date: _____/_____/_____

1.2 Worker Notification and Health Questionnaire

This form contains the notification to the worker and the Safety Critical Worker Health Questionnaire.

The self-administered questionnaire is a screening tool to help identify conditions that might affect the performance of Safety Critical Work. The questionnaire is not a diagnostic tool and no decision can be made regarding the worker's fitness for duty until the full clinical examination is performed.

The Authorised Health Professional may need to guide or assist with completion of the questionnaire if literacy or cultural background presents a barrier to self-administration by the worker. The health professional will also need to review the answers with the worker to ascertain relevant detail.

Dishonest completion of the questionnaire may be an issue. Workers are required to sign the completed questionnaire in the presence of the Authorised Health Professional and the health professional should countersign.

The form is used as follows:

1. ***Part A:*** The employer requests that the worker/applicant sign the front of the form to indicate that they have read and understood the statements concerning the health information to be provided. The employer completes PART A including appointment details and instructions to the worker/applicant.
2. ***Part B:*** The worker/applicant completes PART B and presents to the Authorised Health Professional. The worker/applicant signs the form as a true statement and the health professional countersigns.
3. The employer discusses the results with the worker/applicant. The form is retained by the health professional and filed in the worker's medical record.

FOR PRIVACY REASONS THE COMPLETED FORM SHOULD BE RETAINED BY THE AUTHORISED HEALTH PROFESSIONAL AND NOT RETURNED TO THE RAIL ORGANISATION (other than the Chief Medical Officer if requested)

CONFIDENTIAL

Safety Critical Worker Health Assessment

WORKER NOTIFICATION AND HEALTH QUESTIONNAIRE

(PINK FORM)

IMPORTANT INFORMATION

To the Worker/Applicant,

- You are required to attend a health assessment as a condition of your employment, to assess your fitness for undertaking 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 health professional. **The bottom of the questionnaire must be signed by you in the presence of the examining doctor.**
- Take glasses, hearing aid or any other aids required for safety critical work to the appointment.
- Take all medication that you are currently taking to the appointment or a list of such medications.
- Take photo identification with you to the appointment.
- If you are **High Level Safety Critical Worker (Category 1)** you will be required to have a blood test as part of your assessment. So as to get a true reading of your blood sugar and cholesterol (total and HDL) you should not eat for a minimum of 8 hours (and no longer than 14 hours) before your blood test appointment. You may drink water but should not take sweetened drinks.

What happens if the examining doctor finds a problem with your health?

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 organisation(s) will discuss with you the appropriate action to be taken. This may include:

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

DISCLOSURE OF HEALTH INFORMATION – PLEASE READ CAREFULLY AND SIGN TO INDICATE YOUR UNDERSTANDING OF HOW YOUR HEALTH INFORMATION IS REPORTED, STORED AND ACCESSED

The details of your health assessment will remain confidential and will only be reported to your employer in terms of your fitness for duty. The examining doctor retains all detailed medical papers including your questionnaire responses, test results and the completed record of clinical findings. The examining doctor sends the completed **'Request and Report Form: Safety Critical Worker Health Assessment'** directly to the referring rail organisation indicating your fitness or otherwise for duty.

Where your employer utilises the services of a Chief Medical Officer (CMO), the CMO may request a copy of the examining doctor's clinical report and test results to aid in the management of your health in relation to your work. The CMO must maintain the confidentiality of the records and ensure they are not made available to, or discussed, with any other person within the rail organisation.

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 authorised health professional and the CMO (if relevant) and the reports held by the rail organisation.

WORKERS DECLARATION

I, ____________________________________ (Print Name)

certify that I have read and understood the above statement concerning the health information provided herein.

Signature: ____

Date: ________________________________

PART A1– Employer to complete

1. Worker/Applicant Details	
Family Name:	***First Names:***
Company:	
Location:	
Employee No:	***Date of birth:***

2. Rail Organisation Details		
Supervisor/contact:		
Date of request:	***Phone:***	***Facsimile:***

3. Health Assessment Appointment Details	
Doctor/Practice:	
Address:	
Phone:	***Facsimile:***
Appointment Date:	***Time:***

4. Tests ordered (Category 1 only):

Pathology:

☐ Fasting Cholesterol - Total and HDL (Category 1 only)

☐ Fasting Plasma Glucose (Category 1 only)

Location and appointment time:

____

____

Other:

☐ Resting ECG (Category 1 only)

Location and appointment time:

____

____

5. Other Tests ordered (Category 1 & 2):

☐ Audiometry (Category 1 and 2)

Location and appointment time:

____

____

☐ Drug Screen

Location and appointment time:

____

____

PART A2 – PATHOLOGY REQUEST

Please accept this form as a referral for this employee/applicant to undertake fasting glucose and lipid pathology (total cholestorol and HDL) screening.

Please fax the results of the pathology to the Authorised Health Professional at the address in section (3) above.

Please forward the account to the rail organisation contact at the address in section (2) above.

Pathology Service to complete:

☐ I have sighted the worker's Rail Safety Worker Card Number________________________ **OR**

☐ I have sighted the worker's / applicant's photo ID (driver's licence or passport) Number________________________

Signature: ________________________________ ***Date of pathology attendance:*** _____/_____/_____

Name: ________________________________ *(print)* ***Phone:*** ________________________

Pathology address: ____

PART B - SAFETY CRITICAL WORKER HEALTH QUESTIONNAIRE– Worker to complete

This questionnaire must be completed in order to help assess your fitness for Safety Critical 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 Authorised Health Professional what it means.

The health professional will ask you more questions during the assessment.

		NO	YES
1.	**Are you currently being treated by a doctor for any illness or injury?**	☐	☐
2.	**Are you receiving any medical treatment or taking any medication (prescribed or otherwise)?**	☐	☐

(Please take any medications with you to show the doctor) Please note brief details:

....

....

....

....

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

		NO	YES
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	☐	☐
3.10	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	☐	☐
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 (respond YES if you require a hearing aid)?	☐	☐
3.21	Have you ever had, or been told by a doctor that you had a psychiatric illness or nervous disorder?	☐	☐
3.20	Do you smoke or have you ever been a smoker?	☐	☐
3.22	Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?	☐	☐
3.23	Do you use illicit drugs?	☐	☐

		NO	YES
4.	**Please tick the box 'NO' or 'YES' in response to the following:**		
4.1	Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy?	☐	☐
4.2	Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐	☐

Epworth Sleepiness Scale

4.3 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 have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze off ***2 = moderate chance of dozing***
1 = slight chance of dozing ***3 = high chance of dozing***

Situation	**Chance of Dozing (0 to 3)**			
	0	**1**	**2**	**3**
4.3.1 Sitting and reading	☐	☐	☐	☐
4.3.2 Watching TV	☐	☐	☐	☐
4.3.3 Sitting, inactive in a public place (eg. a theatre or meeting)	☐	☐	☐	☐
4.3.4 As a passenger in a car for an hour without a break	☐	☐	☐	☐
4.3.5 Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
4.3.6 Sitting and talking to someone	☐	☐	☐	☐
4.3.7 Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
4.3.8 In a car, while stopped for a few minutes in the traffic	☐	☐	☐	☐

5. (AUDIT Questionnaire) Please circle the answer that is correct for you:

		(0)	(1)	(2)	(3)	(4)
5.1	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*
5.2	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*
5.3	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*
5.4	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*
5.5	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*
5.6	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*
5.7	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*
5.8	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*
5.9	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*
5.10	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*

6. (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)
6.1	In the past 4 weeks, about how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
6.2	In the past 4 weeks, about how often did you feel nervous?	☐	☐	☐	☐	☐
6.3	In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
6.4	In the past 4 weeks, about how often did you feel hopeless?	☐	☐	☐	☐	☐
6.5	In the past 4 weeks, about how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
6.6	In the past 4 weeks, about how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
6.7	In the past 4 weeks, about how often did you feel depressed?	☐	☐	☐	☐	☐
6.8	In the past 4 weeks, about how often did you feel that everything was an effort?	☐	☐	☐	☐	☐
6.9	In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
6.10	In the past 4 weeks, about how often did you feel worthless?	☐	☐	☐	☐	☐

Worker's Declaration (in presence of health professional):

I, ____ (Print Name)

certify that to the best of my knowledge the above information supplied by me is true and correct

Signature of worker: ____

Signature of health professional: ____

Date: _____/_____/_____

IMPORTANT: For privacy reasons, the completed questionnaire MUST NOT be returned to the employer (other than to the Chief Medical Officer if requested).

1.3 Record for Health Professional

The Health Assessment Record for Health Professionals is a tool that guides the health assessment process. It provides a standard format for recording the results of the assessment, which should then be filed by the Authorised Health Professional in the worker/patient's medical history.

The form should be used as follows:

1. ***Part A:*** The employer completes PART A, and includes the form with the Request and Report Form (Form 1.1) and forwards to the Authorised Health Professional.
2. ***Part B:*** The health professional records the results of the clinical examination in PART B and retains the form in the worker's medical record. The form also includes provision for the worker/patient to provide signed consent for the health professional to contact their treating doctor.
3. The completed Health Assessment Record is not to be forwarded to the employer for reasons of privacy. The Authorised Health Professional should summarise the results in terms of fitness for duty on the Request and Report Form (Form 1.1).

FOR PRIVACY REASONS THE COMPLETED FORM SHOULD BE RETAINED BY THE AUTHORISED HEALTH PROFESSIONAL AND NOT RETURNED TO THE RAIL ORGANISATION
(Other than the Chief Medical Officer if requested)

CONFIDENTIAL

Safety Critical Worker Health Assessment
RECORD FOR HEALTH PROFESSIONAL
(GREEN FORM)

PART A – Employer to complete

1. Worker/Applicant Details	
Family Name:	***First Names:***
Company:	
Location:	
Employee No:	***Date of birth:***

2. Rail Organisation Details		
Supervisor/contact:		
Date of request:	***Phone:***	***Facsimile:***

3. Health Assessment Appointment Details	
Doctor/Practice:	
Address:	
Phone:	***Facsimile:***
Appointment Date:	***Time:***

PART B – Examination Record – Health Professional to complete

1. Cardiovascular System:

1.1 Blood Pressure (repeat if necessary)

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 Score (High Level SCW examination only). See Cardiovascular chapter for scoring.

	Data	Score
Age/sex		
Smoker: Y/N		
Blood Pressure (systolic)		
ECG (left ventricular hypertrophy)		
Fasting cholesterol – TOTAL		
– HDL		
Fasting plasma glucose (diabetes)		
TOTAL SCORE		

(cont)….

1.5 Cardiac Risk Score (cont)

Other clinical considerations *(refer section 4.2 Cardiovascular Disease) eg symptoms, family and past history, co-morbidity, work conditions:*

____

____

2. Musculoskeletal / Neurological:

2.1 Cervical spine rotation

Normal ☐ Abnormal ☐

2.2 Back movement

Normal ☐ Abnormal ☐

2.3 Upper Limbs

a) Appearance: Normal ☐ Abnormal ☐

b) Joint movements: Normal ☐ Abnormal ☐

2.4 Lower Limbs

a) Appearance: Normal ☐ Abnormal ☐

b) Joint movements: Normal ☐ Abnormal ☐

2.5 Gait Normal ☐ Abnormal ☐

2.6 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. Chest/Lungs: Normal ☐ Abnormal ☐

4. Abdomen (liver): Normal ☐ Abnormal ☐

5. Hearing, if required (Audiometry results):

	0.5 kHz	1.0 kHz	2.0 kHz
Right			
Left			

6. Vision:

6.1 Visual Acuity

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

Are contact lenses worn? No ☐ Yes ☐

***6.2 Visual Fields** (Confrontation to each eye):*

Normal ☐ Abnormal ☐

6.3 Colour vision, if required
(Ishihara: ≥ 2 errors/12 plates is a fail)

Pass ☐ Fail ☐

7. Urinalysis

7.1 Protein: Normal ☐ Abnormal ☐

7.2 Glucose: Normal ☐ Abnormal ☐

8. Sleep: Epworth Sleepiness Scale

(Record results from Question 4 of the Health Questionnaire)

Question	Score	Question	Score
Q 4.3.1		Q 4.3.5	
Q 4.3.2		Q 4.3.6	
Q 4.3.3		Q 4.3.7	
Q 4.3.4		Q 4.3.8	
TOTAL SCORE:			

9. Alcohol: Audit Questionnaire

(Record results from Question 5 of the Health Questionnaire)

Question	Score	Question	Score
Q 5.1		Q 5.6	
Q 5.2		Q 5.7	
Q 5.3		Q 5.8	
Q 5.4		Q 5.9	
Q 5.5		Q 5.10	
TOTAL SCORE:			

10. Psychological Health:

10.1 K10 Questionnaire

(Record results from Question 6 of the Health Questionnaire)

Question	Score	Question	Score
Q 6.1		Q 6.6	
Q 6.2		Q 6.7	
Q 6.3		Q 6.8	
Q 6.4		Q 6.9	
Q 6.5		Q 6.10	
TOTAL SCORE:			

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

11. Medications:

(Record details of medications from Question 2 of the Health Questionnaire)

12. Drug Screen:

RELEVANT CLINICAL FINDINGS AND ACTION

Note Comments on any relevant findings detected in the questionnaire or examination, making reference to the requirements of the Standard.

Patient Consent (if required to consult with general practitioner or other treating doctor)

I,____print name

☐ 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

Signature of worker/applicant: ____

(1) Name of Doctor: _________________________ (2) Name of Doctor: _________________________

Phone: ________________________________ Phone: ________________________________

IMPORTANT:

For privacy reasons, the completed Health Assessment Record must not be returned to the rail organisation (other than to the Chief Medical Officer, if requested, who must maintain confidentiality). Please retain in the worker's health record.

1.4 Screen-Based Equipment (SBE) Eye Examination Request and Report Form

Some Safety Critical Workers may perform duties that require them to have a Screen-Based Equipment (SBE) Eye Examination. This model form is designed for this purpose.

The form is used as follows.

1. ***Part A:*** The employer completes PART A and forwards to the Authorised Health Professional together with the SBE Eye Examination Record for Health Professionals (Form 1.5).

   Note: The health professional retains the Examination Record and does not return it to the employer.

2. ***Part B:*** The health professional summarises the results of the examination in PART B of the form and includes recommendations for corrective lenses. The Report Form is then sent to the employer.

3. ***Part C:*** Should corrective lenses be prescribed specifically for SBE work, the worker/applicant has the prescription filled and signs the declaration in PART C.

THE COMPLETED FORM SHOULD BE RETURNED TO THE RAIL ORGANISATION

CONFIDENTIAL

Screen-Based Equipment Eye Examination
REQUEST AND REPORT FORM
(YELLOW FORM)

PART A – Employer to complete

1. Worker/Applicant Details	
Family Name:	***First Names:***
Company:	
Location:	
Employee No:	***Date of birth:***

2. Rail Organisation Details		
Supervisor/contact:		
Date of request:	***Phone:***	***Facsimile:***
Account and report to be sent to Supervisor at the following address (Please insert postal address or fax number):		

3. Health Assessment Appointment Details	
Optometrist:	
Address:	
Phone:	***Facsimile:***
Appointment Date:	***Time:***

PART B - Examination Record – Health Professional to complete and return to employer

Fit SBE work / does not require visual correction.	☐
Fit SBE work / with current prescription.	☐
Current prescription is not suitable for SBE work, therefore there is a need for lenses prescribed specifically for SBE work.	☐
The person requires glasses prescribed specifically for SBE work, because of a visual problem that only arises with SBE work.	☐
I certify I have prescribed glasses that only need to be used for SBE work, as this employee does not need to use glasses for other visual tasks.	☐

Provider Name:	
Provider No:	***Phone:***
Provider Signature:	***Date:***

The above section must be completed by the Optometrist prior to employee re-imbursement

PART C – Worker Declaration – Worker to complete

I have obtained glasses specifically for SBE work as prescribed by this provider. Attached are:

(a) The original itemised receipt

(b) Health Benefit refund towards cost of glasses (if applicable)

Signature:	***Date:***

1.5 Screen-Based Equipment (SBE) Eye Examination Record for Health Professional

This form guides the health professional in undertaking the SBE examination.

The form should not be returned to the employer.

The results should be summarised on the Request and Report form (Form 1.4).

FOR PRIVACY REASONS THE COMPLETED FORM SHOULD BE RETAINED BY THE AUTHORISED HEALTH PROFESSIONAL AND NOT RETURNED TO THE RAIL ORGANISATION (Other than the Chief Medical Officer if requested)

CONFIDENTIAL

Screen-Based Equipment Eye Examination

RECORD FOR HEALTH PROFESSIONAL

(ORANGE FORM)

PART A – Employer to complete

1. Worker/Applicant Details	
Family Name:	***First Names:***
Company:	
Location:	
Employee No:	***Date of birth:***
Is a multi-coloured screen used for Safety Critical Work?	

2. Rail Organisation Details		
Supervisor/contact:		
Date of request:	***Phone:***	***Facsimile:***

3. Health Assessment Appointment Details	
Optometrist:	
Address:	
Phone:	***Facsimile:***
Appointment Date:	***Time:***

PART B – Examination Record – Health Professional to complete and retain

			No	Yes
1.	Does the worker wear glasses or contact lenses? Specify ____________		☐	☐
2.	Is there a history of eye disorders? Specify ____________		☐	☐
3.	Is external eye examination normal? Specify ____________		☐	☐
4.	Is Distance Visual Acuity (Snellen chart) normal?	- Right	☐	☐
	(Fail is 2 or more errors in 6/9 line) Specify ____________	- Left	☐	☐
5.	Is acuity at 45cm and 70cm (Times Roman Chart or equivalent) normal?	- Right	☐	☐
	(Fail is 2 or more errors of 20 words of N6 or N12 respectively) Specify ____________	- Left	☐	☐
6.	Is colour vision (where multi-coloured screens are used for safety critical work) normal? (Ishihara test (fail is 2 or more errors/12 plates)		☐	☐
	If abnormal conduct Farnsworth D15 – Normal? Specify ____________		☐	☐

7. For OHN use: Pass ☐ Refer ☐

8. Clinical Notes: *(In the event of an abnormality being found which requires optical correction, please consider all other optical requirements of the job to be included in the lens prescription).*

____

____

Ref: Eyesight testing of users of screen-based equipment. NOHSC 1992

2. Track Safety Health Assessment

2.1 Request and Report Form

The Request and Report Form for the Track Safety Health Assessment is used as follows:

1. ***Part A:*** The employer asks the worker/applicant to sign the front of the form to indicate that they have read and understood the statements concerning the health information to be provided. The employer completes PART A, encloses a copy of the Health Assessment Record for Health Professionals (Form 2.2) and forwards to the Authorised Health Professional.
2. ***Part B:*** Upon completion of the assessment, the health professional completes PART B of the form, retains a copy and returns the original form to the employer.

   The heath professional also completes the Health Assessment Record (Form 2.2) and retains it.
3. ***Part C:*** The employer completes PART C of the form to indicate the action taken as a result of the health assessment.
4. ***Part D:*** The worker/applicant completes PART D of the form to indicate agreement to the portability of the assessment.

THE COMPLETED FORM SHOULD BE RETURNED TO THE RAIL ORGANISATION

CONFIDENTIAL

Track Safety Health Assessment

REQUEST AND REPORT FORM

(MAUVE FORM)

IMPORTANT INFORMATION

To the Worker/Applicant

- You are required to attend a health assessment as a condition of your employment, to assess your fitness for undertaking rail safety work.
- The health assessment must be completed by (date)________________________ in order to ensure that you are able to carry out normal duties.
- Please ensure that you take to the appointment:
  - glasses;
  - hearing aid or any other aids required for rail safety work.
- The examining health professional may ask your permission to speak to your general practitioner.
- You may be required to attend an audiometry test or drug screen before attending the health assessment.
- If the examining health professional finds or suspects something is wrong with your health that you did not know about, they will ask permission to inform your own doctor. The examining health professional will not treat any medical condition but will give you a letter to take to your own health professional for treatment.
- If the health professional finds that you do not meet all relevant medical criteria your supervisor at the rail organisation(s) will discuss the appropriate action to be taken. This may include modification to the duties that you undertake for that railway organisation or scheduling of a further review, tests or specialist referral

To the Employer

- Please complete all relevant details in PART A of the form including:
  - Personal details of the worker/applicant
  - Appointment details if appropriate
  - Description of the rail safety duties to be performed by the worker/applicant
  - Type of assessment requested.
- Upon receipt of the completed Health Assessment Report from the examining health professional, please complete Section C indicating the action taken, and ask employee to complete Part D as required.

To the Health Professional

- You are requested to conduct a health assessment to assess the worker's/applicant's fitness for rail safety work in accordance with the details provided in PART A of this form and in accordance with Volume 2 of the *Code of Practice for Health Assessment of Rail Safety Workers*.
- Please perform the assessment, complete PART B of this form and return to worker's supervisor according to the instructions in PART A.
- Should the worker be assessed Unfit for Duty please contact the employer immediately so that appropriate rostering changes may be made.
- Details of the assessment should be recorded on the enclosed Track Safety Health Assessment Record form. This record is confidential and should be retained by you, not returned to the employer. The employer's chief medical officer may contact you for more information regarding the worker's condition.
- For more detailed information about the conduct of health assessments for rail safety workers see Volume 2 of the *Code of Practice for Health Assessment of Rail Safety Workers*.

To the Worker: DISCLOSURE OF HEALTH INFORMATION – PLEASE READ CAREFULLY AND SIGN TO INDICATE YOUR UNDERSTANDING OF HOW YOUR HEALTH INFORMATION IS REPORTED, STORED AND ACCESSED

The details of your health assessment will remain confidential and will only be reported to your employer in terms of your fitness for duty. The examining health professional retains all detailed medical papers including your test results and the completed record of clinical findings. The health professional sends only the completed Request and Report form directly to the referring railway organisation indicating your fitness or otherwise for duty. Where your employer utilises the services of a Chief Medical Officer (CMO), the CMO may request a copy of the examining health professional's report to aid in the management of your health in relation to your work. The CMO must maintain the confidentiality of the records and ensure they are not made available to, or discussed with any other person within the rail organisation. Other than the above, no information will be disclosed to the employer or 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 authorised health professional and the CMO (if relevant) and the reports held by the rail organisation.

WORKER'S DECLARATION

I, ____ (Print Name)

certify that I have read and understood the above statement concerning the Health Information provided herein.

Signature: ______________________________________ Date: ____________________________

PART A– Employer to complete

1. Worker/Applicant Details	
Family Name:	***First Names:***
Company:	
Location:	
Employee No:	***Date of birth:***

2. Rail Organisation Details		
Supervisor/contact:		
Date of request:	***Phone:***	***Facsimile:***
Account and report to be sent to Supervisor at the following address (Please insert postal address or fax number):		

3. Health Assessment Appointment Details	
Health professional:	
Address:	
Phone:	***Facsimile:***
Appointment Date:	***Time:***

4. Description of Worker's Duties (or attach Job Description or Task Risk Assessment)

5. Type of Assessment requested

- ☐ Pre-placement / Change of Risk Category Health Assessment
- ☐ Periodic Health Assessment
- ☐ Triggered Health Assessment (specify reason): ______________________________
- ☐ Drug Screen / Review results
- ☐ Screen-Based Equipment Examination
- ☐ Other (specify): ______________________________

6. Tests Ordered

☐ **Drug Screen**

Location (if differs from Health Assessment Appointment details):

____

____

☐ **Audiometry**

Location (if differs from Health Assessment Appointment details):

____

____

Worker/Applicant Name:		
Employee No.	***Date of birth:***	***Date of Request:***

PART B – Health Professional to complete

☐ **I have sighted the worker's Rail Safety Worker Card** **Number________________________ OR**

☐ **I have sighted the worker's/applicant's photo ID (eg driver's licence, passport) Number________________________**

I certify that I have examined the worker/applicant named in accordance with the medical standards contained in the *Code of Practice for Health Assessment of Rail Safety Workers, Volume 2: Assessment Procedures and Medical Criteria* and in my opinion the worker/applicant is *(tick appropriate box)*:

☐ **Fit for Duty –** Meets all relevant medical criteria.	☐ Local doctor referral ☐ Conditional on corrective lenses ☐ Conditional on hearing aid ☐ Other condition (specify): ________________________ ________________________ ________________________
☐ **Fit for Duty Subject to Review** – Does not meet all medical criteria, but could perform current rail safety work if the condition is sufficiently under control and worker is more frequently reviewed than prescribed under periodic review.	**I recommend:** ☐ Review at this practice DATE: ☐ ☐ 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 current rail safety work if suitable modifications were.	**I recommend the following job modifications:** ________________________ ________________________ ________________________
☐ **Temporarily Unfit for Duty Subject to Review** – Does not meet all medical criteria and cannot perform current rail safety tasks but may perform alternative tasks. May return to full duty pending improvement in condition, response to treatment, confirmed diagnosis of undifferentiated illness.	**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.	**I recommend the following in terms of management and review:** ________________________ ________________________ ________________________

Drug Screen Results:

Health Professional Details (stamp acceptable)		
Name:	***Phone:***	***Facsimile:***
Practice address:		
Signature:	***Date of Assessment:***	

PART C – Employer to complete on receipt of Assessment Report

Action taken as a result of Health Assessment:

☐ Job modification (details):________________________

☐ Triggered review (indicate period): ________________________

☐ Periodic Health Assessment scheduled (details): ________________________

☐ Redeployment (details): ________________________

☐ Drug Assessment (details): ________________________

PART D – Worker to complete regarding portability of assessment result

I, ________________________ (Print Name) give permission for this health assessment to be forwarded to another rail organisation as confirmation of fitness for duty.

Signature: ________________________ Date: _____/_____/_____

2.2 Record for Health Professional

The Track Safety Health Assessment Record for Health Professionals is a tool to help guide authorised health professionals with the health assessment process.

It provides a standard format for recording the results of the health assessment which should then be filed in the worker's medical history.

The completed Health Assessment Record is not to be forwarded to the employer for reasons of privacy.

The health professional should summarise the result in terms of fitness for duty on the Request and Report Form (Form 2.1).

FOR PRIVACY REASONS THE COMPLETED FORM SHOULD BE RETAINED BY THE AUTHORISED HEALTH PROFESSIONAL AND NOT RETURNED TO THE RAIL ORGANISATION
(Other than the Chief Medical Officer if requested)

CONFIDENTIAL

Track Safety Health Assessment
RECORD FOR HEALTH PROFESSIONAL
(WHITE FORM)

PART A – Employer to complete

1. Worker/Applicant Details	
Family Name:	*First Names:*
Company:	
Location:	
Employee No:	*Date of birth:*

2. Rail Organisation Details		
Supervisor/contact:		
Date of request:	*Phone:*	*Facsimile:*

3. Health Assessment Appointment Details	
Health Professional:	
Address:	
Phone:	*Facsimile:*
Appointment Date:	*Time:*

PART B – Examination Record – Health Professional to complete

1. Medical History *(tick appropriate box)*

		No	Yes
1.1	Do you have any serious illnesses?	☐	☐
1.2	Do you have any difficulty of vision?	☐	☐
1.3	Do you have any difficulty of hearing?	☐	☐
1.4	Do you have any difficulty walking?	☐	☐

2. Vision:

2.1 Visual Acuity

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

Are contact lenses worn? No ☐ Yes ☐

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

3. Musculoskeletal / Neurological:

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
a) Appearance: Normal ☐ Abnormal ☐
b) Joint movements: Normal ☐ Abnormal ☐

3.5 Gait Normal ☐ Abnormal ☐

3.6 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 ☐

4. Hearing (Audiometry results):

	0.5 kHz	**1.0 kHz**	**2.0 kHz**
Right			
Left			

5. Drug Screen:

____
____
____
____
____
____

Comment on any relevant findings detected in the Health Assessment, making reference to the requirements of the Standard.

____
____
____
____
____
____

Patient Consent (if required to consult with general practitioner or other treating doctor)
I,____(Print Name)

☐ give ☐ do not give **(please indicate)** permission for the examining health professional to contact my treating doctor to discuss or clarify information relating to my current health status.

Signature of worker/applicant: ____

Name of Doctor: ____

Phone: ______________________________

IMPORTANT: For privacy reasons, the completed Health Assessment Record must not be returned to the employer. It should be retained in the patient record.

3. Task Risk Assessment

The Task Risk Assessment is a template form designed to guide the process of risk assessment of rail safety tasks and serve as a documentation of the conclusions of task assessment.

The completed form is recommended as an inclusion with the information provided to the examining health professional and it supports a clearer understanding of the tasks performed by the worker and the matching health requirements.

A detailed explanation of the processes involved in health risk assessment and completion of the Task Risk Assessment Template is included in the *Guideline for Health Risk Management.*

Rail Safety Worker Risk Assessment Template

RAIL SAFETY WORKER TASK:		
ASSESSMENT RECORD:		
WORKSITE INSPECTION	Date:	Completed by:
JOB DESCRIPTION	Date:	Reviewed by:
CONTEXT:		

ACTIVITIES AND WORKING CONDITIONS:	**HEALTH ATTRIBUTES:** ***Health attributes relating to the safety of the rail network:*** ***Health attributes relating to the safety of the rail worker (OHS):***

ENGINEERING AND PROCEDURAL ENVIRONMENT:	
RISK ANALYSIS AND CATEGORISATION:	**CATEGORY**
HEALTH ASSESSMENT REQUIREMENTS:	