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| EMPLOYEE MEDICAL QUESTIONNAIRECONFIDENTIAL | | | | | |
| The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties of the post you have been offered or place you at any risk in the workplace. We may recommend adjustments or assistance as a result of this assessment to enable you to do the job. Our aim is to promote and maintain the health of all people at work. Before health clearance is given for employment you may be contacted by the Rainbow Direct Care and may need to be seen by an occupational health advisor or physician. | | | | | |
| PERSONAL INFORMATION | | | | | |
| Title: |  | First Name: |  | Surname: |  |
| D.O.B |  | Home Telephone |  | Mobile: |  |
| Work Telephone: | |  | | Email: |  |
| Home Address: | |  | | GP Address: |  |

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| MEDICAL HISTORY | |
| All staff groups complete this section | Yes No |
| Do you have any illness/impairment/disability (physical or psychological) which may affect your work? | Yes No |
| Have you ever had any illness/impairment/disability which may have been caused or made worse by your work? | Yes No |
| Are you having, or waiting for treatment (including medication) or investigations at present?  If your answer is yes, please provide further details of the condition, treatment and dates. | Yes No |
| Do you think you may need any adjustments or assistance to help you to do the job | Yes No |
| ADDITIONAL INFORMATION (If you have answered yes to any questions above please provide additional information below) | |

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| TUBERCULOSIS | | | | | | | |
| Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006) | | | | | | Yes No | |
| Have you lived continuously in the UK for the last 5 years? | | | | | | Yes No | |
| If you answered no above, please list all of the countries that you have lived in over the last 5 years | | | | | | | |
| Have you had a BCG vaccination in relation to Tuberculosis? | | | | | | Yes No | |
| If you answered yes please state when | | | | Date: | |  | |
| Do you have any of the following | | | | | | | |
| A cough which has lasted for more than 3 weeks | Yes No | Unexplained weight loss | | | | Yes No | |
| Unexplained fever | Yes No | Have you had tuberculosis (TB) or been in recent contact with open TB | | | | Yes No | |
| ADDITIONAL INFORMATION (If you have answered yes to any questions above please provide additional information below) | | | | | | | |
| CHICKEN POX OR SHINGLES | | | | | | | |
| Have you ever had chicken pox or shingles? | | | Yes No | | Date: | |  |

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| IMMUNISATION HISTORY | | | | | | | | | |
| Have you had any of the following immunisations? | | | | | Yes No | | | Date: |  |
| Triple vaccination as a child (Diptheria / Tetanus / Whooping cough) | | | | | Yes No | | | Date: |  |
| Polio | | | | | Yes No | | | Date: |  |
| Tetanus | | | | | Yes No | | | Date: |  |
| Hepatitis B (If Yes is ticked please give dates below) | | | | | Yes No | | | Date: |  |
| Course: | 1 |  | 2 |  | | 3 |  | | |
| Boosters: | 1 |  | 2 |  | | 3 |  | | |

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| PROOF OF IMMUNITY (Please send the following) | |
| Varicella | You must provide a written statement to confirm that you have had chicken pox or shingles however we strongly advise that you provide serology test result showing varicella immunity |
| Tuberculosis | We require an occupational health/GP certificate of a positive scar or a record of a positive skin test result (Do not Self Declare) |
| Rubella, Measles & Mumps | Certificate of “two” MMR vaccinations or proof of a positive antibody for Rubella Measles & Mumps |
| Hepatitis B | You must provide a copy of the most recent pathology report showing titre levels of 100lu/l or above |

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| PROOF OF IMMUNITY (Please send the following) EPP Candidates Only) | |
| Hepatitis B  Surface Antigen | Evidence of a negative Surface Antigen Test Report must be an identified validated sample. (IVS) |
| Hepatitis C | Evidence of a negative antibody test Report must be an identified validated sample. (IVS) |
| HIV | Evidence of a negative antibody test Report must be an identified validated sample. (IVS) |

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| EXPOSURE PRONE PROCEDURES | |
| Will your role involve Exposure Prone Procedures | Yes No |

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| DECLARATION | | | | | |
| I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I also give consent for Rainbow Direct Care to make recommendations to my employer. | | | | | |
| Signed: |  | Print Name: |  | Date: |  |