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| **Confidential Workplace Health & Wellbeing Pre-Placement Form**  **For Healthcare Workers**  **Revision Date: June 2020** | | | | | | | |
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| **PART 1 - Recruiting Officer to Complete** | | | | | | | |
| Employer name & address |  | | | | | | |
| Job Title |  | | | | | | |
| Department/Area |  | | | Job Ref | |  | |
| Recruiting Officer & telephone number |  | | | Recruiting email address to return outcome report | |  | |
| Substantive  Temporary  Bank / Locum | | | | | | | |
| FT/PT (if PT state hours) |  | | | Start date | |  | |
| **Hazard Categories** | | | | | | | |
| Direct face to face patient contact | |  |  | | Blood / body fluid exposure | |  |
| Exposure prone procedures | |  |  | | Prevention of management of aggression | |  |
| Manual Handling | |  |  | | Crouching / stooping or kneeling | |  |
| Night working / shift work | |  |  | | Frequent hand washing / wearing gloves | |  |
| VDU user | |  |  | | Chemical sensitisers | |  |
| Driving of patients | |  |  | | Noise | |  |
|  | | | | | | | |
| **PART 2 - Applicant to Complete** | | | | | | | |
| **Please note:** Your answers to this questionnaire will remain confidential to the Workplace Health & Wellbeing team and will not be given to anyone else. The disclosure of any physical or mental health issues will not necessarily put you at any disadvantage for the post. 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 to advise on any adaptations or modifications that may be required to assist you in performing the tasks of the job. In addition, we wish to ensure that you will not be placed at risk in the workplace and to help identify if there is a risk of developing work related illness from any health hazards in the post. An appointment with an Occupational Health Adviser or Physician may be required following receipt of this questionnaire.  **Please ensure you answer all questions as full as possible. Failure to complete this questionnaire will result in a delay to your health clearance and subsequent start date.** | | | | | | | |

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| **SECTION A: Personal details** | | | | | | | |
| Surname | |  | | | | | |
| First names | |  | | | Title |  | |
| Previous surname | |  | | | | | |
| Date of birth | |  | | | | | |
| Home address | |  | | | | | |
| Home telephone | |  | | | | | |
| Mobile telephone | |  | | | | | |
| Email address | |  | | | | | |
| **Previous employment** | | | | | | | |
| Is this your first post within the NHS? | | | | Yes | | | No |
| If **no** please indicate which Trust(s) you have previously worked for and dates of service: | | | | | | | |
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| **SECTION B: Medical Information** | | | | | | | |
| Do you have a **health or medical condition** especially any which may be relevant in undertaking the job you have been offered? | | | | | | | |
| Yes | No | | If **yes**, please give details: | | | | |
|  | | | | | | | |
| Do you have or have you a history of **Musculoskelet**al problems affecting (back / upper limbs / lower limbs / neck / shoulder) including arthritis / pain or any difficulties in standing bending lifting or other movements? | | | | | | | |
| Yes | No | | If **yes**, please give details: | | | | |
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| Are you being treated for or have you ever been treated for **Mental Health issues** (including anxiety, depression, eating disorders, alcohol or drug abuse) or do you think you may be suffering from a problem but have not sought help for it? | | | | | | | | | | | | |
| Yes | No | | If **yes**, please give details: | | | | | | | | | |
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| Do you have or have you a history of **Skin conditions** (including eczema, dermatitis, or associated allergies? (e.g. latex) | | | | | | | | | | | | |
| Yes | No | | If **yes**, please give details: | | | | | | | | | |
|  | | | | | | | | | | | | |
| Are you taking any regular prescribed medication? | | | | | | | | | | | | |
| Yes | No | | If **yes**, please give details: | | | | | | | | | |
|  | | | | | | | | | | | | |
| Are you having or waiting for treatment or investigations at present? | | | | | | | | | | | | |
| Yes | No | | If **yes**, please give details: | | | | | | | | | |
|  | | | | | | | | | | | | |
| Have you ever had any health condition / impairment / disability which may have been caused or made worse by your work? | | | | | | | | | | | | |
| Yes | No | | If **yes**, please give details: | | | | | | | | | |
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| Do you think that you may require special adjustments or certain equipment in order to complete the tasks of the job? Have you previously had any adjustments or equipment provided? | | | | | | | | | | | | |
| Yes | No | | If **yes**, please give details: | | | | | | | | | |
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| **SECTION C: Immunisations** | | | | | | | | | | | | |
| ***Please include documentary evidence of all vaccines dates*** | | | | | | | | | | | | |
| **Tuberculosis** | | | | | | | | | | | | |
| BCG Immunisation date | | | | 🡺 | Scar present: | | | | Yes | | | No |
| Heaf / Mantoux date | | | | 🡺 | Heaf grade | | | | Grade | | | |
|  | | | | | Mantoux result | | | | mm | | | |
| *If previously had BCG scar check from Occupational Health Professional, please include documentary evidence* | | | | | | | | | | | | |
| Have you lived / worked continuously in the UK for the last year? | | | | | | | | | | | | |
| Yes | No | | If **no**, please indicate which countries you have lived / worked | | | | | | | | | |
|  | | | | | | | | | | | | |
| Do you have any of the following: | | | | | | | | | | | | |
| Cough or night cough lasting more than 3 weeks? | | | | | | | | Yes | | No | | |
| Unexplained weight loss? | | | | | | | | Yes | | No | | |
| Unexplained fever/ night sweats? | | | | | | | | Yes | | No | | |
| Do you have active tuberculosis (TB) */* latent TB / are you being treated for TB */* have you tested positive for TB in the last year / have you been in recent contact with someone known to have or suspected to have TB? | | | | | | | | | | | | |
| Yes | No | | If **yes**, to any of the above, please explain below: | | | | | | | | | |
|  | | | | | | | | | | | | |
| Have you ever tested positive for TB or been treated for TB in the past including as a precaution? | | | | | | | | | | | | |
| Yes | No | | If **yes**, please explain below: | | | | | | | | | |
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| **MMR** | | | | | | | | | | | | |
| Dose 1 immunisation date | | | | | | Dose 2 Immunisation date | | | | | | |
| ***OR*** *previous single dose vaccine of* | | | | | | | | | | | | |
| **Rubella** | | | | | | | | | | | | |
| Immunisation date | | | | | | | | | | | | |
| Blood test date | | | | 🡺 | Result | | | | | | | |
| **Measles** | | | | | | | | | | | | |
| Immunisation date | | | | | | | | | | | | |
| Blood test date | | | | 🡺 | Result | | | | | | | |
| **Chicken Pox** | | | | | | | | | | | | |
| Definite history Chicken Pox or Shingles? - includes being able to recall spots, being unwell or recall having calamine lotion applied or scars from spots | | | | | | | | | Yes | | No | |
| Do you originate from overseas? | | | | | | | | | Yes | | No | |
| If **yes** please specify country | | | | | | | | | | | | |
| Do you have evidence of VZV serology | | | | | | | | | Yes | | No | |
| Dose 1 immunisation date | | | | | | Dose 2 Immunisation date | | | | | | |
| **Hepatitis B** | | | | | | | | | | | | |
| Full course completed date | | | | | | | | | | | | |
| Last booster | | | | | | | | | | | | |
| Last blood test date | | | | 🡺 | Result | | | | | | | |
| **Hepatitis C** | | | | | | | | | | | | |
| Blood test date | | | | 🡺 | Result | | | | | | | |
| **HIV** | | | | | | | | | | | | |
| Blood test date | | | | 🡺 | Result | | | | | | | |
| **Polio** | | | | | | | | | | | | |
| Immunisation date | | | | | | | | | | | | |
| **Tetanus** | | | | | | | | | | | | |
| Immunisation date | | | | | | | | | | | | |
| **If involved with EPP\* - please send ID Verified UK lab result for Hep B Antibody & Hep B Surface Antigen.**  **If you commenced doing EPPs after Jan 2003 please send ID verified UK lab result for Hep C Antibody.**  **If you commenced doing EPPs after Jan 2008 please send ID verified lab result for HIV Antibody.** | | | | | | | | | | | | |
| **Exposure Prone Procedures** | | | | | | | | | | | | |
| \*Exposure Prone Procedures (EPPs) are those procedures where the workers gloved hand may be in contact with sharp instruments, needle tips or sharp tissue (e.g. spicules of bones or teeth) inside a patients open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. | | | | | | | | | | | | |
| Have you previously been involved in Exposure Prone Procedures (EPP) in the UK? | | | | | | | | | Yes | | No | |
| If **yes** please give dates | | From: | | | | | To: | | | | | |
| **Covid-19 Screening Questions**  What is your ethnicity? What is your weight? | | | | | | | | |  | |  | |
| What is your height? | | What is your BMI? | | | | |  | | | | | |
| **EPP staff are required to provide documentary evidence of blood results to Blood Borne Virus’. These must be identified validated samples (IVS). Health clearance for EPP work cannot be given until these results have been received. *IF YOU HAVE PREVIOUS BLOOD RESULTS PLEASE SUPPLY A COPY WHEN YOU SUBMIT THIS FORM*.** | | | | | | | | | | | | |
| ***IF RESULTS ARE NOT SUPPLIED YOU WILL BE TESTED IN THIS DEPARTMENT*. You will be asked to show formal photographic ID i.e. valid driver’s licence, passport or Trust ID for this procedure. This is to comply with the Department of Health’s standard for Identified Validated samples (IVS).** | | | | | | | | | | | | |

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| **SECTION D: Declaration** | | | | | |
| I declare that the information I have given is correct to the best of my knowledge. I understand that I may be contacted by a member of the Workplace Health & Wellbeing Team to discuss information or the requirement of a clinical assessment. I understand that this offer of appointment or continued employment may be affected if I have intentionally left out any details or answered untruthfully.   I understand that a outcome certificate will be sent from Workplace Health & Wellbeing to the recruiting officer based on the above information provided. I understand that no confidential or personal health information will be released without my consent. | | | | | |
|  | | | | | |
| Signed |  |  | Dated |  |  |
|  | | | | | |
| ***PLEASE NOTE***  *This Pre-Placement Form will comprise part of your Occupational Health record once submitted. If you do not take up the post your completed form will be destroyed within 12 months.*  *All Occupational Health records are held in accordance with the Data Protection Regulation (GDPR) and Access to Medical Reports Act (1988). Electronic Occupational Health records are stored on a secure server which can only be accessed by the Occupational Health team using log in / passwords. Paper records are stored securely in locked cabinets and only the Occupational Health team have access to the keys. Access to the office is restricted to Occupational Health or authorised staff only. The office is locked during out of office hours so no one can access any information.*  *If you wish to view or receive a copy of your Occupational Health records held by Workplace Health & Wellbeing, we require a formal request and we will respond to your request within one month.* | | | | | |

**Please return this form by email to –** [**workplace.health@nnuh.nhs.uk**](mailto:workplace.health@nnuh.nhs.uk)

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