Dear Medical Officer,

We know that your time is very valuable to you. For that reason, the Auckland Regional DHBs are developing a regional process to streamline the health screening process.

Purpose of Pre-employment Health Screening

Pre-employment health screening is a process developed to identify potential or actual risks to the employee, due to exposure to work related hazards. To assist in meeting our legal obligations, ARRMOS requires relevant health information from you. This enables us to make recommendations to your placement manager, if necessary, regarding reasonable modifications in the workplace to keep the employee safe at work. This information also establishes a baseline for future health monitoring and health protection. This information is also collected to protect the staff and patients of the Auckland Regional DHBs (ADHB, CMDHB and WDHB).

Instructions:

- Complete and sign the attached questionnaire.

- Attach any documentation that you have on previous immunity status checks including:
  - Hepatitis B
  - Varicella (Chicken Pox)
  - Measles, Mumps & Rubella (MMR)
  - 2 Step Mantoux tests/ Heaf tests / TB blood tests (Quantiferon TB Gold)
  - Chest X-Ray report (If you had positive Mantoux/Heaf/TB blood test previously)
  - MRSA results less than 2 months old

- Attach documentation on immunisation records for the following:
  - Hepatitis B
  - Varicella
  - Measles, Mumps or Rubella (MMR)
  - BCG (for Tuberculosis)

Return your completed form to Occupational Health and Safety Service, Private Bag 93311, Otahuhu

Your form and documentation will be reviewed by Occupational Health and Safety. You may be asked to carry out tests. If so, you will be sent written communication and a laboratory form.

You may be asked to make an appointment with the Occupational Health and Safety Service at the District Health Board where you are currently placed.

The overall process including tests, interpretation of results and clearance takes a minimum of 8 working days from the time you have the tests. If follow up is required, then the process will take longer.

Thanks for your assistance,

Auckland Regional DHB occupational health and safety services

Auckland Regional DHB occupational health and safety services
Registered Medical Officer - Pre-Employment Health Questionnaire

Ms / Mrs / Miss / Mr (please circle)	
Family Name (Surname):	
Given Name (First Name):	
Preferred Name:	
Date Of Birth:	
NHI:	
Postal Address:	
Email Address:	
Home Phone Number:	
Mobile Number:	
Proposed Start Date:	
Position Applied For:	L O C U M
Work Area:	
Placement Manager:	
DHB Starting at:	☐ ADHB ☐ CMDHB ☐ WDHB

Please specify your Educational Institute and any District Health Board (DHB) that you have worked for?		
Educational Institute		
District Health Board		
Do you have Healthcare Workers Vaccination passport? (If yes, please attach a copy to this form)	Yes ☐	No ☐

1. General

a	Have you any disability that may require some modification in the workplace relevant to this job?	Yes ☐	No ☐

If Yes, Please specify:

b	Do you currently have an ACC claim which remains open and that caused you to have time off work?	Yes ☐	No ☐

If Yes, Please specify:

c	Do you give permission for Auckland Regional OHS to gain a copy of information relating to this current claim from your health care provider or ACC?	Yes ☐	No ☐

Signature:

2. Safety Critical Work

The following conditions may result in sudden loss of consciousness under certain circumstances, and therefore may require special workplace accommodation.

	Do you have, or have you had in the past any of the following conditions that have been managed by a Health Professional:		
a	Epilepsy	Yes ☐	No ☐
b	Diabetes	Yes ☐	No ☐
c	High Blood Pressure	Yes ☐	No ☐
d	Low Blood Pressure	Yes ☐	No ☐
e	Heart Problems	Yes ☐	No ☐
f	An episode of loss of consciousness	Yes ☐	No ☐
g	Serious head injury	Yes ☐	No ☐
h	Stroke	Yes ☐	No ☐
i	Are you currently on any medication, that is likely to affect your ability to work safely	Yes ☐	No ☐
j	Would working shift work be a health problem for you?	Yes ☐	No ☐

If you answered yes to any of the above, please explain :

3. Musculo-Skeletal Health

Have you ever had?

Back/Neck/Shoulders/Leg problems?	Yes ☐ No ☐	In the last year?	Yes ☐ No ☐
		In the last 1-5 years?	Yes ☐ No ☐
Musculo-Skeletal problems? (E.g.: Repetitive strain injury)	Yes ☐ No ☐	In the last year?	Yes ☐ No ☐
		In the last 1-5 years?	Yes ☐ No ☐
Strain/Sprain that would be affected by manual handling?			Yes ☐ No ☐
Any other physical conditions that may affect your work?			Yes ☐ No ☐

If ticked "Yes" to any question above, please provide the following details:

What was your injury / condition?	
Date of injury / condition?	
What were the symptoms of the injury / condition?	
When did you last have symptoms?	
What treatment did you have?	
Did you have referred pain?	
How much time off work did you have?	
Do you have any concerns now, about the effect of this injury on your ability to carry out the job you are currently applying for?	
Comments	

4. Vision

a	Do you have any vision difficulties i.e. for reading, driving and/or performing technical procedures etc?	Yes ☐	No ☐
b	Do you have colour blindness?	Yes ☐	No ☐

If you answered yes to any of the above please explain:

5. Allergies and Other Sensitivities

Do you have, or have you had in the past:

a	Asthma/other respiratory conditions	Yes ☐	No ☐
b	Allergies (e.g.: drugs, food, pollen, latex, other)	Yes ☐	No ☐
c	Previous reactions to any particular substance that you may be exposed to in the course of your work.	Yes ☐	No ☐

If you answered yes to any of the above please explain:

6. Psychological Health

a	Are you currently or have you ever been under the care of a Health Professional with regard to a mental health condition i.e. Depression, Psychosis, Schizophrenia, Anxiety, deliberate self harm	Yes ☐	No ☐

If Yes, Please specify:

b	Are you currently receiving therapy for this condition?	Yes ☐	No ☐
c	Do you require special consideration due to psycho-social issues, e.g.: shift work, enclosed spaces, heights, high stress environments?	Yes ☐	No ☐

If Yes, Please specify:

7. MRSA

a	Do you have a chronic skin condition such as dermatitis or eczema?	Yes ☐	No ☐
b	Chronic sinusitis?	Yes ☐	No ☐
c	Bronchiectasis?	Yes ☐	No ☐

8. Tuberculosis:

Baseline Personal Tuberculosis Information

1) What country were you born in?	
Ethnicity : ☐ NZ European ☐ NZ Maori ☐ Pacific Island ☐ Other European	
☐ Other (State):	
2) Please list the countries you have resided in within the past 2 years:	
3) Do you have a chronic illness such as kidney disease, asthma, diabetes, HIV or any immunosuppressive illness?	Yes ☐ No ☐
If **"Yes"**, Please provide details	
4) Do you take any oral steroids or other medication?	Yes ☐ No ☐
If **"Yes"**, Please state name of medication:	
5) Have you ever been treated for Tuberculosis?	Yes ☐ No ☐
If **"Yes"**, When?	
6) Have you ever been exposed to anyone with TB in your work or home environment?	Yes ☐ No ☐
If **"Yes"**, were you classified as a close contact?	
If **"Yes"**, what and where was the follow up required?	
7) Have you ever been vaccinated with a BCG?	Yes ☐ No ☐
8) Have you ever had a Mantoux test, heaf test or blood test for TB infection (Quantiferon TB Gold)?	Yes ☐ No ☐
If **"Yes"**, what was the result?	
Have you ever been told that you should not have any more Mantoux tests because you have had a positive Mantoux reading?	Yes ☐ No ☐
9) Have you had a Chest X-Ray within the last year?	Yes ☐ No ☐

Tuberculosis Symptom Questionnaire

This Questionnaire relates to the symptoms of Tuberculosis.

1) Do you have as much energy as you think you should have for your age? (Please tick your answer) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 **No Energy** **Energy to Burn**	Yes ☐	No ☐
2) Do you have a persistent cough or a cough most days?	Yes ☐	No ☐
3) Does your cough produce a lot of phlegm?	Yes ☐	No ☐
4) Have you ever coughed up blood?	Yes ☐	No ☐
5) Do you wake at night sweating so much you have to change your bed clothes?	Yes ☐	No ☐
6) Have you lost any weight over the last 6 months without meaning to? If YES, how much? _____ Kg	Yes ☐	No ☐
7) Have you had urinary tract infections without your doctor being able to find a cause?	Yes ☐	No ☐
8) Have you had any lumps in your neck which won't go away?	Yes ☐	No ☐

9. Blood & Body Fluid Exposure

a	Have you ever had a work-related blood/body fluid exposure e.g. needle stick injury?	Yes ☐	No ☐
b	If yes, are you on a monitoring programme related to this?	Yes ☐	No ☐
c	If yes, do you give consent for Auckland region OHS to obtain a copy of relevant baseline and follow up test information from your previous employer?	Yes ☐	No ☐

10. Other Infectious Diseases

Infectious diseases	Have you ever had any of these infections?			lab results attached
Hepatitis B	Yes ☐	No ☐	Unsure ☐	☐
Hepatitis C	Yes ☐	No ☐	Unsure ☐	☐
Chickenpox	Yes ☐	No ☐	Unsure ☐	☐
Measles	Yes ☐	No ☐	Unsure ☐	☐
Mumps	Yes ☐	No ☐	Unsure ☐	☐
Rubella	Yes ☐	No ☐	Unsure ☐	☐

SMOKE FREE POLICY

The Auckland Regional District Health Boards all have a Smoke Free Policy which prohibits staff and visitors from smoking anywhere in its facilities or grounds.

If you smoke and wish to obtain assistance to quit, a Smoking Cessation Programme is available to all staff at each Auckland DHB. Please ask for details.

Privacy Statement

I _____ *(full name)* declare that to the best of my knowledge the answers in this application are correct. I understand that if any false or deliberately misleading information is given, or any material fact suppressed, I may not be appointed, or if I am employed, my employment may be terminated.

I authorise permission for Auckland Regional DHB Occupational Health and Safety units to gain access to my personal immunity status and immunisation information held at my Educational Institute.

I also understand that the information related to health screening required by ARRMOS will be placed on my personal file and I have a right to access it. I also consent to the Auckland Regional DHB Occupational Health and Safety units disclosing this information to other DHB Occupational Health and Safety units in relation to their Pre-Employment Health Screening, Contact Tracing or Health Monitoring requirements and my nominated General Practitioner subject to the Privacy Act 1993.

Declaration Statement

I declare to the best of my knowledge that the information given is correct.

I understand and accept that I may be required to attend a health assessment with the Auckland Regional DHB Occupational Health and Safety health practitioners.

I understand that withholding information or supplying incorrect or misleading information on this questionnaire may result in my being disqualified for appointment to the position, or if appointed, my subsequent dismissal.

Name:		**Signature:**	
Date:			

(OH&SS Office Use Only)				
	Title	Verification provided (✓)	Tests referred by OH&SS(✓)	Referred to OHP (✓)
1	General Information		N/A	N/A
2	Safety Critical Work		N/A	
3	Musculo-Skeletal Health			
4	Vision			
5	Allergies and other sensitivities			
6	Psychological Health			
7	MRSA			
8	Tuberculosis			
9	BBFE			
10	Hepatitis B			
	Varicella (Chicken Pox)			
Privacy & Declaration statement			N/A	N/A

NOTES (OH&SS Office Use Only)

Occupational Health Clearance (OH&SS Office Use Only)	
☐	Employable without limitations
☐	Employable with limitations ☐Ergonomic ☐ Physical ☐Biological ☐ Chemical ☐Psychosocial
☐	Temporarily not able to perform the job tasks
☐	Unable to perform the requirements of the job

Manager notified	☐	OHN Signature:		Date:	