

	NSW Coal Industry Periodic Health Surveillance Assessment	
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CONSENT TO UNDERGO PERIODIC HEALTH SURVEILLANCE ASSESSMENT

Name: _____ Date of Birth: _____ Gender: M F
Address: _____

I understand that I am required as part of my employment to have health surveillance assessments for the purpose of safeguarding my health & safety.

1) I consent to undergo a periodic health surveillance assessment with

Doctor's / Registered Nurse's name: _____

Practice name: _____

2) I understand that my medical records are managed according to strict legal and ethical guidelines. No specific detail concerning my medical conditions will be released to a third party without my written consent.

3) I understand that the assessing Doctor / Registered Nurse may communicate with my treating Doctor(s) regarding my medical condition, and may request relevant reports.

Doctor's name: _____

4) I consent to the assessing Doctor / Registered Nurse releasing my medical data to Coal Services Pty Limited for inclusion in the NSW coal mineworker's health database for the purpose of ongoing health surveillance.

Signed: _____

Date: _____

Name: _____

Photo ID

Type: _____

Number: _____

Witness: _____

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Periodic Health Assessment

Medical history

Details of any significant operation or medical illness:

Previous injuries:

Medications:

Allergies:

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Hazard Exposure

What hazards are you exposed to at work?

Physical:	Noise	Y	N	Sun and other UV-light	Y	N
	Whole body vibration	Y	N	Hand-arm vibration	Y	N
Dusts:	Coal	Y	N	Asbestos	Y	N
	Hard Rock (Silica)	Y	N			
Chemical:	Diesel exhaust	Y	N	Solvents	Y	N
	Oils	Y	N	Welding fume	Y	N
	Phenol	Y	N	Purisocyanate mixture	Y	N
	Other Chemical: _____					
Psycho Social:	Shiftwork	Y	N	Stress	Y	N

How often do you use the following items of personnel protective equipment?

	Sometimes	Mostly	Always	Never	Type (if known)
Respirator	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Gloves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hearing protection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Long sleeves and pants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Hat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sun glasses	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sun screen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Boots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Eye protection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Do you have difficulty wearing personal protective or self rescue equipment? Y N

If yes, please give details: _____

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Work related / skin disease

Do you currently have any skin problems or dermatitis? Y N If no, line of questioning ceases

Do you believe this skin trouble may be work related? Y N If no, line of questioning ceases

If yes, what do you think is the cause? _____

What kind of skin disease do you have?

- | | | | |
|-----------------------------|-----------------------|-----------------------------|-----------------------|
| Irritant contact dermatitis | <input type="radio"/> | Allergic contact dermatitis | <input type="radio"/> |
| Fungal infection | <input type="radio"/> | Eczema | <input type="radio"/> |
| Skin Cancer | <input type="radio"/> | Uncertain | <input type="radio"/> |

What site is involved?

- | | | | | | |
|-------|-----------------------|-------|-----------------------|------|-----------------------|
| Hands | <input type="radio"/> | Feet | <input type="radio"/> | Arms | <input type="radio"/> |
| Legs | <input type="radio"/> | Trunk | <input type="radio"/> | Face | <input type="radio"/> |
| Other | <input type="radio"/> | | | | |

What skin hazards are you exposed to?

- | | | | | | |
|-----------------------|-----------------------|-----------------|-----------------------|-------|-----------------------|
| Sun or other UV light | <input type="radio"/> | Solvents | <input type="radio"/> | Other | <input type="radio"/> |
| Latex rubber | <input type="radio"/> | Grout | <input type="radio"/> | | |
| Detergents | <input type="radio"/> | Oil and greases | <input type="radio"/> | | |

Comments: _____

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Standardised Respiratory Questionnaire (if indicated)

Preamble:

I am going to ask some questions, mainly about your chest. I would like you to answer **Yes** or **No** whenever possible.

Use the actual wording of each question. When in doubt record answer as 'No'.

If the subject is disabled from walking from any condition other than heart or lung disease, please begin questionnaire at Question 5 and mark the adjacent box.

Breathlessness and Wheezing

During the last month

- | | | | |
|-----|--|---|---|
| Q1. | Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? | Y | N |
| | If Yes to Q1: | | |
| Q2. | Do you get short of breath walking with other people of your own age on level ground? | Y | N |
| Q3. | Do you have to stop for breath when walking at your own pace on level ground? | Y | N |
| Q4. | If you run or climb stairs fast do you ever | | |
| | a. cough? | Y | N |
| | b. wheeze? | Y | N |
| | c. get tight in the chest? | Y | N |
| Q5. | Is your sleep ever broken | | |
| | a. by a wheeze? | Y | N |
| | b. by difficulty in breathing? | Y | N |

If Yes to Q5 please record details of any occupational exposure to respiratory hazards?

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- Q6. Do you ever wake up in the morning (or from your sleep if a shift worker)
- | | | |
|-------------------------------|---|---|
| a. with a wheeze? | Y | N |
| b. with difficulty breathing? | Y | N |

- Q7. Do you ever wheeze
- | | | |
|--------------------------------------|---|---|
| a. if you are in a smokey room? | Y | N |
| b. if you are in a very dusty place? | Y | N |

If Yes to either Q4, Q5, Q6 or Q7:

- Q8. Are your symptoms better
- | | | |
|---|---|---|
| a. at weekends (or equivalent if a shiftworker) | Y | N |
| b. when you are on a holiday? | Y | N |

Cough

- Q9. Do you usually cough first thing in the morning in winter? Y N
- Q10. Do you usually cough during the day - or at night - in winter? Y N

If Yes to Q9 or Q10:

- Q11. Do you cough like this on most days for as much as three months each year? Y N

Phlegm

- Q12. Do you usually bring up phlegm from your chest first thing in the morning in winter? Y N
- Q13. Do you usually bring up phlegm from your chest during the day - or at night - in winter? Y N

If Yes to Q12 or Q13:

- Q14. Do you bring up phlegm like this on most days for as much as three months of the year? Y N

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Periods of coughing and phlegm

Q15. In the past 3 years, have you had a period of (increased) cough and phlegm lasting for three weeks or more? Y N

If Yes to Q15:

Q16. Have you had more than one illness like this in the past three years? Y N

Chest Illnesses

Q17. During the past 3 years, have you had any chest illness that has kept you from your usual activities for as much as a week? Y N

If Yes to Q17:

Q18. Did you bring up more phlegm than usual in any of these illnesses? Y N

If Yes to Q18:

Q19. Have you had more than one illness like this in the past three years? Y N

Q20. Have you ever had, or been told that you have had:

- | | | | |
|----|--|---|---|
| a. | An injury or operation affecting your chest? | Y | N |
| b. | Heart trouble? | Y | N |
| c. | Bronchitis? | Y | N |
| d. | Pneumonia? | Y | N |
| e. | Pleurisy? | Y | N |
| f. | Tuberculosis? | Y | N |
| g. | Bronchial asthma? | Y | N |
| h. | Other chest trouble? | Y | N |
| i. | Hay fever? | Y | N |

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Q21. Do you smoke? Y N

If No to Q21:

Q22. Have you ever smoked as much as one cigarette a day for as long as one year? Y N

If No to Q21 or Q22, omit the remaining questions on smoking

Q23. How old were you when you started smoking regularly _____

Q24a. Do (did) you smoke manufactured cigarettes? Y N

If Yes to Q24a:

How many do (did) you usually smoke per day:

Q24b. On weekdays? _____

Q24c. On weekends? _____

Q25. Do you smoke any other forms of tobacco? Y N

Details: _____

For Ex-smokers

Q26. When did you give up smoking altogether? Month ____ Year ____

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Musculoskeletal questionnaire

1. Do you work:

Underground

Outbye Face Surface

Do you wear a utility belt? Y N

What type of belt? _____

Is the belt comfortable? Y N

If no, could it be improved with:

Padding Shoulder straps Wider belt Other _____

Open Cut

Operator Driller Shotfirer Maintenance

Washery Technician Administrator Supervisor

2. Have you had any significant pain or discomfort during the last year that lasted for a week or longer? Y N

If No, finish questionnaire

If Yes, please indicate where:

Neck <input type="radio"/>	Shoulder <input type="radio"/>	Wrist <input type="radio"/>
Chest <input type="radio"/>	Upper Back <input type="radio"/>	Lower Back <input type="radio"/>
Hips <input type="radio"/>	Knees <input type="radio"/>	Ankles <input type="radio"/>
Other _____		

3. Has the pain resolved? Y N

If No, go to Q4.

If Yes, go to Q6.

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4. Which word best describes your symptoms?

- | | | | |
|--------------------------------|--------------------------------|---------------------------------|--------------------------------|
| Aching <input type="radio"/> | Burning <input type="radio"/> | Cramping <input type="radio"/> | Numbness <input type="radio"/> |
| Pain <input type="radio"/> | Swelling <input type="radio"/> | Stiffness <input type="radio"/> | Tingling <input type="radio"/> |
| Weakness <input type="radio"/> | | | |

5. How long do these symptoms last?

- < 1 month 1-3 months 3-6 months over 6 months

6. Have you received any medical treatment for this condition? Y N

7. Have you lost any time off work due to this problem? Y N

If no, go to Q9.

If yes, how long?

- < week 1-4 weeks 1-3 months >3 months

8. Have you been on restricted duties due to this condition? Y N

If no, go to Q10.

If yes, how long?

- < week 1-4 weeks 1-3 months >3 months

9. How long have you been working at this job? _____

10. Can you control the order and pace of your tasks usually dependent on other (machines, computers, customers)? Y N

12. Do you usually work under time pressures and deadlines? Y N

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13. In your current role are you required to do the following?

Task	Never	Infrequent	Half the time	Frequently	Constantly
Lift objects over 20kg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drag hoses or cables	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work with your arms above chest height	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drive heavy plant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climb stairs, ramps, ladders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walk on uneven ground	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Operate powered tools	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Maintain a fixed posture for extended periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Use keyboards/screens for extended periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. Are you exposed to vibration? Y N

If yes, which sources do you find most uncomfortable?

Heavy trucks	<input type="radio"/>	Dozers	<input type="radio"/>	Other heavy plant	<input type="radio"/>
Powered hand tools	<input type="radio"/>	Light transport vehicles	<input type="radio"/>	Fixed machinery	<input type="radio"/>
Other	<input type="radio"/>				

Comments _____

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Epworth sleepiness scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired?

This refers to your usual way of life in recent times. Even if you haven't done some of the 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:

	Score 0	Score 1	Score 2	Score 3
	Would never doze	Slight chance of dozing	Moderate chance of dozing	High chance of dozing
Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting inactive in a public place (e.g. cinema or in a meeting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being in a car for an hour as a passenger (without a break)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon (where possible)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and chatting to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after lunch (not having had alcohol)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car when you stop in traffic for a few minutes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Total Score: If your score is >15 refer to GP for assessment.

Has the miner been referred to his GP? Y N

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Alcohol Audit

	Score 0	Score 1	Score 2	Score 3	Score 4
	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
1. How often do you have a drink containing alcohol?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
2. How many standard drinks containing alcohol do you have on a typical day when drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
3. How often do you have six or more drinks on one occasion?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. During the past year, how often have you found that you were unable to stop drinking once you had started?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. During the past year, how often have you failed to do what was normally expected of you because of drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. During the past year, how often have you needed a drink in the morning to get yourself going after a heavy drinking session?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. During the past year, how often have you had a feeling of guilt or remorse after drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. During the past year, have you been unable to remember what happened the night before because you had been drinking?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Score 0		Score 1		Score 2		Score 3		Score 4
--	------------	--	------------	--	------------	--	------------	--	------------

	No		Yes, but not in the past year		Yes, during the past year
--	----	--	----------------------------------	--	------------------------------

9. Have you or someone else been injured as a result of your drinking?

10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested you cut down?

How many standard drinks would you consume on average per week? grams

Score

If score is greater than 8, consider referral to GP for further assessment.

Has miner been referred to his GP? Y N

Comments

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K10 Questionnaire - Psychological Health

Please tick the answer that is correct for you:	All of the time (score 5)	Most of the time (score 4)	Some of the time (score 3)	A little of the time (score 2)	None of the time (score 1)
1. In the past 4 weeks, about how often did you feel tired out for no good reason?					
2. In the past 4 weeks, about how often did you feel nervous?					
3. In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?					
4. In the past 4 weeks, about how often did you feel hopeless?					
5. In the past 4 weeks, about how often did you feel restless or fidgety?					
6. In the past 4 weeks, about how often did you feel so restless that you could not sit still?					
7. In the past 4 weeks, about how often did you feel depressed?					
8. In the past 4 weeks, about how often did you feel that everything was an effort?					
9. In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?					
10. In the past 4 weeks, about how often did you feel worthless?					

If score is greater than 19, refer to GP for assessment.

Has miner been referred to his GP? Y N

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Coronary Heart Disease

Risk Factor Prediction Chart

1. Find points for each risk factor

Age (if female)		Age (if male)		HDL - Cholesterol		Total Cholesterol		Systolic BP	
Age	Pts	Age	Pts	HDL-C	Pts	Total-C	Pts	SBP	Pts
30	-12	30	-2	0.65-0.68	7	3.60-3.99	-3	98-104	-2
31	-11	31	-1	0.69-0.75	6	4.00-4.30	-2	105-112	-1
32	-9	32-33	0	0.77-0.84	5	4.31-4.60	-1	113-120	0
33	-8	34	1	0.85-0.90	4	4.70-5.19	0	121-129	1
34	-6	35-36	2	0.91-0.99	3	5.20-5.69	1	130-139	2
35	-5	37-38	3	1.00-1.09	2	5.70-6.19	2	140-149	3
36	-4	39	4	1.10-1.19	1	6.20-6.79	3	150-160	4
37	-3	40-41	5	1.20-1.30	0	6.80-7.49	4	161-172	5
38	-2	42-43	6	1.31-1.43	-1	7.50-8.19	5	173-185	6
39	-1	44-45	7	1.44-1.56	-2	8.20-8.55	6		
40	0	46-47	8	1.57-1.70	-3				
41	1	48-49	9	1.71-1.89	-4				
42-43	2	50-51	10	1.90-2.07	-5				
44	3	52-54	11	2.08-2.25	-6				
45-46	4	55-56	12	2.26-2.49	-7				
47-48	5	57-59	13						
49-50	6	60-61	14						
51-52	7	62-64	15						
53-55	8	65-67	16						
56-60	9	68-70	17						
61-67	10	71-73	18						
68-74	11	74	19						

Other	Pts
Cigarettes	4
Diabetic-Male	3
Diabetic -Female	6
ECG-LVH	9
0 points for each NO	

2. Sum points for all risk factors

Age + HDL-C + Total C + SBP + Smoker + Diabetic + ECG_LVH

Note: Minus points subtract from total

TOTAL POINTS CARDIAC RISK SCORE See next page for Probability Scores.

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3. Look up risk corresponding to Cardiac Risk Score

Probability (%)			Probability (%)			Probability (%)			Probability (%)		
Pts	5yr	10yr	Pts	5yr	10yr	Pts	5yr	10yr	Pts	5yr	10yr
< 1	< 1	< 2	10	2	6	19	8	16	28	19	33
2	1	2	11	3	6	20	8	18	29	20	36
3	1	2	12	3	7	21	9	19	30	22	38
4	1	2	13	3	8	22	11	21	31	24	40
5	1	3	14	4	9	23	12	23	32	25	42
6	1	3	15	5	10	24	13	25			
7	1	4	16	5	12	25	14	27			
8	2	4	17	6	13	26	16	29			
9	2	5	18	7	14	27	17	31			

4. Compare to Average 10 year risk

Probability (%)		
Age	Women	Men
30-34	< 1	3
35-39	< 1	5
40-44	2	6
45-49	5	10
50-54	8	14
55-59	12	16
60-64	13	21
65-69	9	30
70-74	12	24

Cardiac Risk Score:

For Cardiac Risk Score > 15: Clarify risk factors and correlate with clinical findings; provide a follow up plan such as GP or cardiologist referral where indicated; determine fitness for work

N/A

For Cardiac Risk Score > 30: Unfit for all safety critical work pending cardiologist review

High Risk? Y N

Spirometry

	Measured	FEV1 _____ litres	FVC _____ litres	RATIO	<input style="width: 80px; height: 20px;" type="text"/>
	Predicted	FEV1 _____ litres	FVC _____ litres		<input style="width: 80px; height: 20px;" type="text"/>
	Percentage predicted	_____	_____		

Spirometry Result Normal Obstructive Restricted Mixed

Doctor to report (if CXR performed)

Is the chest xray normal?	Y	N	Pneumoconiosis grade (if known)	<input style="width: 80px; height: 20px;" type="text"/>
If no, is the abnormality respiratory related?	Y	N		

If yes, is it related to:

Asbestos related dust disease	<input type="radio"/>	Silica related dust disease	<input type="radio"/>	Malignancy	<input type="radio"/>	Emphysema	<input type="radio"/>
Coal related dust disease	<input type="radio"/>	Fibrotic lung disease	<input type="radio"/>	Non-specific changes	<input type="radio"/>		

If no, is it related to:

Cardiac	<input type="radio"/>	Malignancy	<input type="radio"/>	Skeletal	<input type="radio"/>	Other	<input type="radio"/>
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Comments _____

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Audiometry Proforma

Relevant History _____

- 16 hrs pre quiet? Y N
- Recent ear and sinus infection? Y N
- TMs normal? Y N
- Is Tinnitus present now? Y N

Comments: _____

Hearing Loss

- Is the pattern of the audiogram consistent with noise induced hearing loss? Y N
- Is there any significant change in the loss since the last recorded audiogram? Y N

										Right/Left Loss	Binaural Loss
<input type="radio"/>	Right										
	Left										
<input type="radio"/>	Retest R										
	Retest L										

Recommendations for review

Routine

Other

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		Mark
	O'Neill	

Examiner's declaration

I (insert name of examiner).....
a registered medical practitioner/nurse, certify that on (insert date).....
personally examined (examinee's name).....
and the information recorded above arose from that examination.

.....

Signature

Stamp