

	NSW Coal Industry Pre-placement Health Surveillance Assessment	
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CONSENT TO UNDERGO MEDICAL ASSESSMENT

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

Address: _____

1) I consent to undergo a health assessment for the position of _____ with employer _____.

2) I understand that this may include urine testing for illicit drugs and breath testing for alcohol.

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

Doctor's name: _____

4) I understand that the assessing Doctor will release a report to my employer that includes information on my relevant medical history, current medications and injury history.

5) I understand that the assessing Doctor may discuss my medical condition with a representative of the proposed employer.

6) I consent to the assessing Doctor 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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Pre-placement Health Assessment

Doctor to complete

Work History

Work history:

Workers' compensation claims:

Medical History

Details of any significant operation or medical illness:

Previous injuries (non-work related):

Relevant medications:

Allergies

Do you have any allergies?

Y N

Smoking History

Do you smoke?	Y	N
If yes,		
How many cigarettes/day?	_____	
For how long have you been a smoker?	_____	
If no,		
Did you ever smoke?	Y	N
For how many years?	_____	
When did you stop?	_____	
How many cigarettes/day?	_____	
Grams tobacco/week?	_____	

Alcohol

Drinkers:	Current consumption - grams alcohol/week?	_____
Non-drinkers:	Were you ever a 'regular' drinker (>500gm/wk?)	Y N

Physical Activity

Do you participate in vigorous exercise outside work for more than 30 minutes and 4 times or more a week?	Y	N
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Comments (smoking / alcohol)

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Pre-placement Health Surveillance Assessment**

Clinical Findings

Vision

Vision meets:

Commercial driver standard Unconditional Conditional Requires corrective lenses
Private vehicle standard Unconditional Conditional

CVS

Normal Abnormal

Heart Sounds N A

Rhythm N A

Character N A

Respiratory

Spirometry Result Normal Obstructive Restricted Mixed

Pneumoconiosis Grade: _____

Breath Sounds N A
Respiratory system N A

Comments _____

Date of last CXR: ____/____/____

Outcome Normal Significant Abnormality Not Applicable

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Musculoskeletal Function

Gait and general posture	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Cervical Spine	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Thoracolumbar Spine	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Upper Limbs	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Lower Limbs	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>

Comments _____

Gastro-intestinal

Abdomen	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Hernias	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>

Comments _____

Neurological

Coordination	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Power	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Sensation	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Reflexes				
Knee	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Ankle	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Other	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
Rhomberg's Test	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>

Comments _____

Exposed Skin

	Normal	<input type="radio"/>	Abnormal	<input type="radio"/>
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Comments: _____

Audiometry

Auditory canals normal?	Y	N
Timpanic membranes normal?	Y	N
Hearing loss consistent with NIHL?	Y	N
Hearing meets commercial driver standards?	Y	N
Hearing meets national rail standard?	Y	N

Comments: _____

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Current health issues:

Examinee referred to other health provider Y N

Referral notes:

Doctor referred to: _____

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Doctor or Nurse to complete

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?

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

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- 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 ____

Audiometry

Relevant History _____

At least 16 hrs since significant noise exposure?	Y	N
Recent ear and sinus infection?	Y	N
Is Tinnitus present now?	Y	N

Comments: _____

										Right/Left Loss	Binaural Loss
○	Right										
	Left										
	Retest R										
○	Retest L										

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Doctor's/Nurse's declaration:

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

.....

Signature

Stamp