

CONFIDENTIAL

**IMPORTANT INFORMATION
TO THE CONTRACTOR/WORKER**

- You are required to attend a health assessment to assess your fitness for safety critical work at RailCorp
- Instructions for arranging your health assessment, and things you need to do beforehand, are on page 3
- The authorised health service provider may ask your permission to speak to your general practitioner or treating specialist and if you agree, will then ask you to sign a document providing written consent to such contact
- If the authorised health service provider finds or suspects something is wrong with your health that you did not know about, they will ask permission to inform your doctor. The examining health professional will not treat any medical condition but will give you a letter to take to your own health professional
- If the authorised health service provider finds that you do not meet all relevant medical criteria, your manager and RailCorp may discuss the appropriate action to be taken

TO THE CONTRACTOR/WORKER - DISCLOSURE OF HEALTH INFORMATION

Please read carefully and sign below to indicate your understanding of how your health assessment information will be reported, stored and accessed. The authorised health service provider retains all detailed medical papers relating to your health assessment including your test results and the completed record of clinical findings. The authorised health service provider sends only this completed BLUE form and the drug and alcohol test results direct to your firm and RailCorp to indicate your fitness for safety critical work. The details of your health assessment will remain confidential and will only be reported to your firm and to RailCorp in terms of your fitness for safety critical work unless you give the health service provider a separate, specific written authorisation to disclose any relevant medical information that impacts on your ability to do your job.

The exception to the above is that RailCorp's Chief Health Officer (CHO) may access your full medical records and test results to aid in the management of your health in relation to your work, for audit purposes, or to compile statistics. The CHO must maintain the confidentiality of these records and ensure they are not made available to, or discussed with, any person within RailCorp.

Other than the above, no information will be disclosed to your firm or any other person or organisation without your written permission, except where:

- a notifiable disease is diagnosed which must by law, be reported to the State authorities, or
- a report is subject to subpoena or a statutory disclosure requirement, or
- the rail safety regulator (or another person) is required to conduct an inquiry into a railway accident or incident, or
- a person or organisation is appointed to conduct an audit of the health service provider's compliance with the National Standard for Health Assessment of Rail Safety Workers, or
- de-identified statistical information related to RailCorp's health assessment process is compiled and provided to RailCorp, or
- there is another lawful purpose.

You have the right to access your health records including those held by the authorised health professional and the records held by RailCorp.

CONTRACTOR/WORKERS DECLARATION

I,.....(print Name)
certify that I have read and understood the above statement concerning the disclosure of my health information. I consent to these conditions so the health assessment can proceed, and my fitness for safety critical work can be assessed

Signature: date. /...../20.

For the Contractor/Worker to complete regarding PORTABILITY OF ASSESSMENT RESULTS

I,.....(print Name)
Give Do not give permission for this health assessment to be forwarded to another rail organisation as confirmation of fitness for safety critical work.

Signature: date. /...../20.

TO THE CONTRACTOR'S FIRM

TO THE HEALTH PROFESSIONAL

Please complete all relevant details in Part A of the form including:

- personal details of the worker/applicant, and
- appointment details, once these are confirmed by the health service provider after you have booked the appointment.

Also complete contractor's name, date of birth and contact details at top of Part B.

Note: To be certain that the individual is fit for rail safety work, the health assessment should be finalised before any relevant training course is booked. Note that the urine drug test results will take at least two days to be available and that the health assessment cannot be finalised without these results.

The authorised health service provider needs to be provided with the original of this form, at least 3 business days in advance of the scheduled appointment.

You are requested to conduct a health assessment to assess the worker's / applicant's fitness for safety critical work in accordance with:

- details provided in Part A of this form,
- Volume 2 of the National Standard for Health Assessment of Rail Safety Workers, and
- RailCorp Authorised Health Professional Terms of Reference

Please perform the assessment, complete Part B of this form and return it to the nominated contact at the contracting firm according to the instructions in Part A.

NB: If the outcome is Temporarily or Permanently Unfit, and/or if the drug or alcohol test is positive, a copy of Part B should be faxed to RailCorp on 02 9752 8951 or emailed to petersham_competencycards@railcorp.nsw.gov.au

CONFIDENTIAL**PART A – ORDER – RAILCORP SAFETY CRITICAL EXAMINATION REQUIRED FOR CONTRACTOR**

TO: Name of Examiner/Location	
RE: Proposed Examination on (Date/Time)	
Type of Health Assessment Required	<input type="checkbox"/> CAT 1 Pre-employment <input type="checkbox"/> CAT 2 Pre-employment

SEND INVOICE & HEALTH ASSESSMENT REPORT TO

Nominated Manager's name		Phone	
		Mobile	
Name of firm:		Fax	
Postal Address			
Postcode:		Email:	

CONTRACTOR DETAILS

Family Name:	First Names:
Postal Address:	
Postcode:	Date of Birth:

PROPOSED WORK FOR RAILCORP

Describe the work the contractor will be doing for RailCorp (e.g. track protection, track machine operator, track vehicle operator, mobile plant operator)	
Describe any additional OH&S requirements	
List competencies / qualifications	
Identify colour vision requirement	<input type="checkbox"/> Normal <input type="checkbox"/> Safe A <input type="checkbox"/> Safe B <input type="checkbox"/> Nil

OTHER TESTS/SERVICES ORDERED

Mandatory drug and alcohol screening tests	<input checked="" type="checkbox"/> AS/NZS 4308 drug test from accredited laboratory <input checked="" type="checkbox"/> Alcohol breath test
Cardiac Risk Assessment Tests (Category 1 only)	<input type="checkbox"/> Fasting Cholesterol (total and HDL) <input type="checkbox"/> Fasting Plasma Glucose

CONFIDENTIAL**How to arrange the health assessment****Step 1 – Make an appointment to have a blood test (Category 1 only)**

- You may attend any pathology collection centre
- You must have a blood test **at least 3 days before your health assessment appointment**
- This blood test is used to measure your blood sugar and cholesterol levels
- Do not eat or drink anything (except water) for at least 8 hours before your blood test. Normally this involves fasting overnight followed by an early morning blood test before having breakfast
- You will need to advise the pathology collection centre of the name and address of the health service that will be conducting your assessment so that your pathology results may be referred
- Photo identification will be required

Step 2 – Make an appointment for your health assessment

- You may select any service from the enclosed list of RailCorp authorised health providers. An examination performed by a non-authorised health provider will not be accepted by RailCorp
- Enter details of your appointment below as a reminder

Time	
Date	
Name and address of health provider	

Step 3 – Complete the health questionnaire on the following two pages

- The questionnaire is a screening tool to help identify conditions that might affect the performance of safety critical work

Step 4 – Attend the health assessment

Take with you to your health assessment appointment:

- The health questionnaire (completed but not signed)
- A list of all medications you are taking, including over-the-counter medicines.
- Any relevant medical reports or test results
- Your blood sugar record (if you are diabetic)
- Photo identification
- Any spectacles, contact lenses, hearing aids or any other aids required for your work

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SAFETY CRITICAL WORKER – HEALTH QUESTIONNAIRE

For privacy reasons, the completed questionnaire **MUST NOT** be returned to RailCorp (except on request to the Chief Health Officer who must maintain privacy). The health service provider retains the completed questionnaire in the worker's health record file

CAT1 – HIGH LEVEL SAFETY CRITICAL WORKER

CAT2 - SAFETY CRITICAL WORKER

Worker Details

Family name:		First names:	
Street address:		Town/city:	
Postcode:	Date of birth:	Home Phone/mobile:	

**COMPLETE ALL THE ANSWERS TO THIS QUESTIONNAIRE BEFORE ATTENDING THE MEDICAL EXAMINATION
SIGN THE FOLLOWING DECLARATION WHEN YOU ARE WITH THE EXAMINING HEALTH PROFESSIONAL**

I,(Print Name) certify that to the best of my knowledge all the information supplied in the following questionnaire is true and correct.

Signature of worker..... Witnessed by Health Professional.....
Date:/...../.....20..... Date:/...../.....20.....

Safety Critical Worker – Health Questionnaire – Page 1

NO YES

1.	Are you currently being treated by a doctor for any illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Are you receiving any medical treatment or taking any medication (prescribed or otherwise)? <i>Provide brief details below and take your medications with you to show the doctor</i>	<input type="checkbox"/>	<input type="checkbox"/>
.....			
.....			
.....			

3. Have you ever had, or been told by a doctor that you had, any of the following:		NO	YES	NO	YES		
3.1	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	3.13	Double vision, difficulty seeing	<input type="checkbox"/>	<input type="checkbox"/>
3.2a	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	3.14	Colour blindness	<input type="checkbox"/>	<input type="checkbox"/>
3.2b	Any family history of heart disease	<input type="checkbox"/>	<input type="checkbox"/>	3.15	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
3.3	Chest pain, angina	<input type="checkbox"/>	<input type="checkbox"/>	3.16	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
3.4	Any condition requiring heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	3.17	Neck, back or limb disorders	<input type="checkbox"/>	<input type="checkbox"/>
3.5	Palpitations / irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	3.18	Hearing loss or deafness or had an ear operation or use a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
3.6	Abnormal shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	3.19	Do you have difficulty hearing people on the telephone? (respond YES if you require a hearing aid)	<input type="checkbox"/>	<input type="checkbox"/>
3.7	Head injury, spinal injury	<input type="checkbox"/>	<input type="checkbox"/>	3.20a	Have you ever been a smoker?	<input type="checkbox"/>	<input type="checkbox"/>
3.8	Seizures, fits, convulsions. epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	3.20b	If you are a smoker, how much do you smoke a day? (e.g. number of cigarettes)	
3.9	Blackouts or fainting	<input type="checkbox"/>	<input type="checkbox"/>	3.20c	If you were a smoker, when did you last stop smoking?	
3.10	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	3.21	Have you ever had, or been told by a doctor that you had, a psychiatric illness or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
3.11	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	3.22	Have you ever had any other serious injury, illness, operation, or been in hospital for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
3.12	Dizziness, vertigo, problems with balance	<input type="checkbox"/>	<input type="checkbox"/>	3.23	Do you use illicit drugs?	<input type="checkbox"/>	<input type="checkbox"/>

CLINICAL NOTES

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Safety Critical Worker – Health Questionnaire – Page 2 For privacy reasons, the completed questionnaire MUST NOT be returned to RailCorp (except on request to the Chief Health Officer who must maintain privacy). The health service provider must retain the completed questionnaire in the worker's health record file							
4	SLEEP	NO	YES	Clinical Use Only			
4.1	Have you ever had, or been told by a doctor that you had, a sleep disorder, sleep apnoea, or narcolepsy?	<input type="checkbox"/>	<input type="checkbox"/>				
4.2	Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	<input type="checkbox"/>	<input type="checkbox"/>				
EPWORTH SLEEPINESS SCALE How likely are you to doze off or fall asleep (rather than feeling just tired) in the following situations: ? <i>This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.</i> Tick the box that best describes your behaviour in each situation		0 Would never doze off	1 Slight chance of dozing	2 Moderate chance of dozing	3 High chance of dozing Official Use Only	
4.3	Sitting and reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4.4	Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4.5	Sitting, inactive in a public place (eg. a theatre or a meeting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4.6	As a passenger in a car, for an hour without a break	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4.7	Lying down to rest in the afternoon when circumstances permit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4.8	Sitting and talking to someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4.9	Sitting quietly following lunch with no alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4.10	In a car, while stopped for a few minutes in the traffic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					TOTAL		
5. AUDIT QUESTIONNAIRE		0	1	2	3	4	Clinical Use Only
Tick the box Please circle the answer that is correct for you:							
5.1	How often do you have a drink containing alcohol?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.2	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 to 5	5 to 6	7 to 9	10 or more	
5.3	How often do you have six or more drinks on one occasion?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.4	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.5	How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.6	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.7	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.8	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week	
5.9	Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
5.10	Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL		
6. K10 QUESTIONNAIRE		1	2	3	4	5	Clinical Use Only
Tick the box that is correct for you							
In the past 4 weeks, about how often did you feel:		None of the time	A little of the time	Some of the time	Most of the time	All of the time	
6.1	Tired out for no good reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.2	Nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.3	So nervous that nothing could calm you down?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.4	Hopeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.5	Restless or fidgety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.6	So restless you could not sit still?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.7	Depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.8	That everything was an effort?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.9	So sad that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.10	Worthless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					TOTAL		

