



## Pre-Placement Health Declaration

Surname	
Forename(s)	
Date of Birth	
National Insurance Number	
Company Name	
Job Title	

*All contractors working at AWE are required to undergo a pre-placement health assessment before starting work on site. This assessment requires you to fill in the form below and will include a drug and alcohol screen and possibly hearing or vision test depending on the hazards of your job. All medical information will be kept confidential but AWE and your employer will be informed of the result of your assessment.*

I consent / do not consent to undergoing a drug and alcohol screen and a medical assessment by Trident Medical Services

Signed ..... Date .....

**Please answer each question below by indicating with a tick under *Yes* or *No*.**

### Section 1

	Do you have or have you ever had:	YES	NO
1.	Illness or disease affecting the heart? (Angina, heart attack, pains in the chest, or pacemakers)		
2.	Illness or disease of the chest or lungs? (Asthma, bronchitis, T.B. pleurisy or emphysema, wheezing)		
3.	Illness or disease affecting the kidneys or bladder?		
4.	Illness or disease affecting the stomach or bowel?		
5.	Illness or disease affecting the blood?		
6.	Any problems with your back? (Sciatica, slipped disc, backache, neck ache or spinal disorders)		
7.	Illness or accidents affecting your joints?		
8.	Any tingling, coldness or numbness in your hands or fingers at work or at home		
9.	Problems with your skin? (Sensitivity, dermatitis, eczema, psoriasis or rashes)		
10.	Disease of, or operations on your eyes?		
11.	Disease of the ears?		
12.	Fainting, blackouts or dizzy spells?		
13.	Fits or Epilepsy?		
14.	Allergies of any kind?		
15.	Diabetes?		
16.	Concussion or a serious head injury?		
17.	Mental health problems? (Depression, schizophrenia, anxiety or stress)		
18.	Medical or surgical treatment of any kind since childhood, from age 16 onwards?		
19.	Are you taking any medicines of any kind?		
20.	Do you think you have a disability?		
21.	Have you ever been rejected or discharged from a job on medical grounds?		
22.	Do you have any other condition which may be affected by the type of work that that you will be doing, or anything you consider relevant and not covered in the list above? <b>(Please give details in comments box overleaf in Section 2)</b>		
23.	Have you been absent from work or school in the last 12 months for 1 week or more for any medical reason? <b>(If yes please state reason/s and date/s in comments box overleaf – Section 3)</b>		

## Section 2

### Comments Box

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## Section 3

### Sickness Absence from work

Reason For Absence	Dates of Absence

Please sign below

I declare that the above information is, to the best of my knowledge, true and complete.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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### For Office Use Only: Pre-placement Screening Required

Drug And Alcohol

Audiometry/FWT

HAVs Assessment

To see OHA

Skin Assessment

Distance Vision

Paper Assessment


Other

Appointment Date: \_\_\_\_\_

**RESULTS**







<b>Identity Confirmed</b>	<b>Yes</b>	<b>No</b>	<b>Height</b>	<b>Weight</b>	<b>BMI</b>	<b>B/P</b>
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<b>Urinalysis</b>				<b>Drug &amp; Alcohol Test</b>	
<b>Sugar</b>	<b>Blood</b>	<b>Protein</b>	<b>Other</b>	<b>Yes</b>	<b>No</b>

<b>Visual Acuity</b> 	<b>Distance Vision</b>			<b>Contact Lenses</b>	<b>YES</b>	<b>NO</b>
	<b>Left</b>	<b>Right</b>	<b>Both</b>			
				<b>Glasses Worn</b>	<b>YES</b>	<b>NO</b>

<b>Skin Assessment</b>	<b>Yes</b>	<b>No</b>	<b>Where?</b>
Any dryness or cracking?			
Any redness?			

<b>Hearing</b>	<b>Yes</b>	<b>No</b>
Normal conversation heard?		

<b>Vibration White Finger Assessment</b>	<b>Yes</b>	<b>No</b>	<b>Right</b>	<b>Left</b>
1. Have you ever suffered from your fingers going white on exposure to cold?				
2. Have you ever had any tingling in your fingers>				
3. Have you ever had any feelings of numbness in your fingers>				
4. Do you have any problems with the muscles or joints of your hands or arms?				

**TRIDENT MEDICAL SERVICES**

Date	Clinical Notes	Signature

Medical Fitness Category	Tick as applicable ✓	Examining Nurse
Fit		Signature  Name  Title  Date
Fit with adjustments		
Temporarily unfit		
Unable to decide on fitness - need further information from GP/Specialist		
To see O H Physician		
<b>Examinee informed of results</b>		
Feedback form sent to management and AWE		
Referral form sent to West End Minor Injuries Unit		