OH1
Occupational Health Risk Assessment Form

Cheshire Occupational Health Service

Part A to be completed by the recruiting manager to identify risks relevant to the post which may require occupational health involvement and/or assessment. Where a risk is identified please refer to the 'Risk identification managers guidance' document for further advice and to determine if Occupational Health intervention/Health Assessment is required and indicate this in the final columns. Where baseline health surveillance is indicated, the identified elements of this role **must not** be undertaken until advice is received from Occupational Health.

1	**Employer Name**	Click here to enter text.
2	**Vacancy Reference**	Click here to enter text.
3	**Position Title**	Click here to enter text.

A Risk Assessment

4	Area of Assessment	Risk Present? (If Yes refer to guidance)	OH Health Assessment Needed
1	Drivers (of company vehicles or who transport service users)	<Select>	<Select>
2	Vocational Driving (e.g. LGV, PCV) *	<Select>	<Select>
3	Food Handling/Preparation (preparation, cooking & serving)	<Select>	<Select>
4	Manual Handling	<Select>	<Select>
5	Contact with patients *(involved in direct patient care)*	<Select>	<Select>
6	Contact with patients (social contact in clinical environment)	<Select>	<Select>
7	Working with those who are at risk of blood borne infections	<Select>	<Select>
8	Undertaking exposure prone procedures.	<Select>	<Select>
9	Exposure to respiratory sensitisers *	<Select>	<Select>
10	Working with biological agents *	<Select>	<Select>
11	Working at heights	<Select>	<Select>
12	Working in isolation	<Select>	<Select>
13	Exposure to skin sensitisers *	<Select>	<Select>
14	Exposure to noise.	<Select>	<Select>
15	Working with vibrating tools	<Select>	<Select>
16	Working with electrical wiring	<Select>	<Select>
17	Working in confined spaces	<Select>	<Select>
18	Working night shifts	<Select>	<Select>
19	Working with extremes of hot and cold temperature	<Select>	<Select>
20	Requirement to perform control and restraint procedures	<Select>	<Select>
21	Any other occupational hazards *	<Select>	<Select>

* if Yes specify below

Click here to enter text.

B Sign Off

5	**Form Completed By**	Click here to enter text.
6	**Date Completed**	Click here to enter a date.

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East Cheshire NHS Trust

Mid Cheshire Hospitals NHS Foundation Trust

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Health Declaration Questionnaire	
INSTRUCTIONS: Please complete the health questionnaire on-line or in BLACK INK. You should email/post your questionnaire to Cheshire Occupational Health Service as detailed below.	
Cheshire Occupational Health Service **Mid Cheshire Hospitals NHS Foundation Trust, Leighton Hospital, Middlewich Road, Crewe, CW1 4QJ** **Email: tmc-tr.OccupationalHealth@nhs.net** **Telephone Crewe: 01270 612372**	
I understand that any information is considered **IN-CONFIDENCE** and will not be divulged without my permission to any person outside of the occupational health service. Information provided is required to reach an opinion regarding your fitness to work based on the assessment of your functional capability. A report on your ability to perform your role will only be given to management. Any employee who wishes to gain access to information stored by OH should apply in writing to the occupational health service.	
Surname:	Title:
Previous Surname:	Gender: Male☐Female☐
First Names:	
Date of Birth: / /	
Home Address:	
Email Address:	
Home Telephone Number:	
Mobile Telephone Number:	
Have you previously worked for this Trust? YES ☐ NO ☐ If yes when did you leave?	
General Practitioner's Name and Address:	
Position applied for:	
Trust/Hospital:	
Department:	
I ACCEPT THAT IN THE EVENT OF BEING EMPLOYED; IF IT IS SUBSEQUENTLY FOUND THAT RELEVANT INFORMATION HAS NOT BEEN DISCLOSED, OR HAS BEEN MISLEADING OR FALSE, THEN I COULD BE LIABLE TO DISCIPLINARY PROCEEDINGS THAT MAY LEAD TO DISMISSAL. ACCEPT ☐ DECLINE ☐ IT IS ESSENTIAL THAT YOU PROVIDE PHOTOGRAPHIC IDENTIFICATION SHOULD YOU BE REQUIRED TO ATTEND AN APPOINTMENT E.G. PASSPORT, DRIVING LICENCE	

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		YES	NO	DETAILS (INCLUDING DATES)
1A	**Disability Discrimination Act 1995 as amended 2005 now Equality Act 2010** You would be regarded as disabled if you have a medical condition that has lasted or is likely to last for more than one year and is sufficient to impair normal day to day activities. Conditions e.g. Cancer, HIV and Multiple Sclerosis are considered disabilities at the point of diagnosis. The Trust is committed to making reasonable adjustments to accommodate individuals with disabilities. Disability does not preclude consideration for employment. Do you believe you have a condition that is likely to be covered by the Equality Act? If YES please provide details	☐	☐	
1B	Do you have any illness/impairment which may affect your work? If YES please provide details	☐	☐	
2	Have you ever been restricted from working due to your health? If YES please provide details	☐	☐	
3	Have you ever required any adjustments or restrictions to your workplace due to your health? If YES please provide details	☐	☐	
4A	Are you currently awaiting treatment /investigations? If yes please provide details.	☐	☐	
4B	Are you currently receiving any treatment and/or medication that could affect your ability to work? If YES please provide details	☐	☐	
5A	Were you born in the UK? If NO what is your country of origin? IF NO how long have you resided in the UK? Please provide details.	☐	☐	
5B	Have you lived in other countries? If yes which? And for how long? Please provide details	☐	☐	
5C	Have you returned from working or living abroad in the past year? If YES please provide details of countries visited and length of stay	☐	☐	
6	Have you had Tuberculosis (TB) or contact with Tuberculosis? **If YES please provide details**	☐	☐	
6a	History of coughing up blood? **If YES please provide details**	☐	☐	
6b	Cough that lasted for more than 3 weeks within the last year? **If YES please provide details**	☐	☐	

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6c	Unexplained loss of weight, fever or night sweats in the last year? **If YES please provide details**	☐	☐	
7	Do you have skin problems e.g. Eczema/ Psoriasis/Dermatitis. State where on the body? **If YES please provide details**	☐	☐	
8	Do you have any allergies? **If YES please provide details**	☐	☐	
9	Is there anything else you feel Occupational Health need to consider regarding your proposed employment? **If YES please provide details**	☐	☐	

This section should be completed by those health care workers and volunteers having clinical contact with patients and laboratory /portering and estates workers whose working will involve contact with patients or body fluids.

IMPORTANT: IN THE ATTEMPT TO PREVENT UNNECESSARY OCCUPATIONAL HEALTH APPOINTMENTS PLEASE PROVIDE ANY DOCUMENTARY EVIDENCE OF VACCINATION AGAINST THE FOLLOWING ILLNESSES.

EVIDENCE OF VACCINATION/SEROLOGICAL TESTS CAN BE OBTAINED FROM YOUR CURRENT OCCUPATIONAL HEALTH DEPARTMENT, GENERAL PRACTITIONER, CHILD HEALTH CLINIC OR TRAVEL CLINIC.

10.	Have you ever been vaccinated against the following?	YES	NO	DETAILS OF VACCINATION/SEROLOGY
A	Triple Vaccine. Diphtheria, tetanus, and whooping cough	☐	☐	
B	Tetanus	☐	☐	
C	Polio	☐	☐	
D	Rubella (German Measles)	☐	☐	
E	MMR (Measles, mumps and rubella)	☐	☐	
F	Varicella (Chicken Pox) (or had history of Chicken Pox/ Date?)	☐	☐	
G	TB (Tuberculosis)	☐	☐	
H	BCG scar present? Usually left upper arm	☐	☐	
I	Hepatitis A (completed course)	☐	☐	
J	Hepatitis B (completed course)	☐	☐	
K	Combined Hepatitis A&B (Completed course)	☐	☐	
L	Meningitis C	☐	☐	

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11.	BLOOD TESTING (CLINICAL STAFF ONLY): IF YOUR EMPLOYMENT INVOLVES EXPOSURE PRONE PROCEDURE I.E. SURGEONS, THEATRE SCRUB NURSES, MIDWIVES, DENTISTS, DENTAL NURSES, YOU MUST PROVIDE COPIES OF YOUR MOST RECENT HEPATITIS B SURFACE ANTIBODY, HEPATITIS B SURFACE ANTIGEN AND HEPATITIS C ANTIBODY AND HIV ANTIBODY RESULTS. FAILURE TO PROVIDE RECENT RESULTS MAY RESULT IN RETESTING AND DELAY IN COMMENCEMENT OF EMPLOYMENT.				
	Have you been tested for the following?	**Yes**	**NO**	**Result:**	**Date:**
A	Hepatitis B antibody	☐	☐		
B	Hepatitis B surface antigen	☐	☐		
C	Hepatitis C antibody	☐	☐		
D	HIV 1&2 antibody	☐	☐		
E	Measles antibody	☐	☐		
F	Rubella antibody	☐	☐		
G	Varicella antibody	☐	☐		
H	Mumps antibody	☐	☐		
I	Interferon gamma test (TB)	☐	☐		
12.	**ADDITIONAL INFORMATION:**				