work health solutions LIMITED

Work Health Solutions Limited

Consent for examination pursuant to the Health and Safety in Employment Act 1992

I ____ being an employee / prospective employee of ______________________________________ Limited ("the Employer") confirm that I understand and agree to be examined for the purposes of a UKOOA (OGUK) or BOSIET employment related medical exam and drug and alcohol testing.

I further consent to health information and results arising from my examination and related to my employment or prospective employment with the Employer to be released to the Human Resource Manager or equivalent officer within the Employer organisation and to be provided to the medical providers identified on this consent form and to Helicopters New Zealand and to M&O Pacific. I am aware that information relating to my fitness to drive may need to be released to the New Zealand Transport Agency (NZTA), irrespective of whether or not I consent to that being done.

I understand that this consent will continue until such time as I advise otherwise.

I further consent to Work Health Solutions Limited obtaining from my nominated health providers such information relating to my health as is necessary for my proper examination. I also consent to Work Health Solutions Limited consulting with specialist medical professionals, should the need arise, for the purpose of interpreting test results.

Signature: ______________________________

Employee / prospective employee

Date: ______________________________

Nominated health providers (please list your family doctor and /or specialist here):

Doctor	Address	Contact phone number

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MEDICAL SCREENING QUESTIONNAIRE AND EXAMINATION RECORD

Surname:	Forenames:	Gender: M☐ / F☐
Address:		Tel No:
Email address for confidential medical information to be sent to you:		
Date of Birth:		
GP's Name:		
GP's Address:		
Can we contact your GP to obtain further medical information or send copies of your examination results if necessary? Y☐ / N☐		
Date of Last Offshore Medical:		
Offshore Occupation/Job Title:		
Emergency Response Role:		Nil ☐

Social / Occupational History	Yes / No	Comments
1. Do you smoke? If so, how many per day?	Y☐ / N☐	
2. If an ex-smoker, when did you give up?	Y☐ / N☐	
3. Do you drink alcohol? If yes please state weekly amount and type.	Y☐ / N☐	
4. Have you ever been exposed to any known occupational hazard such as noise, radiation, dusts, asbestos, chemicals or lead?	Y☐ / N☐	
5. Do you use protective clothing, safety glasses or hearing protection?	Y☐ / N☐	
6. Have you ever developed any medical condition in connection with your occupation? If so, please give details, e.g. hearing loss/ skin condition/wheeze/backache/muscle strain/ blood disease?	Y☐ / N☐	
7. Have you ever suffered any industrial injury? If so, please give details.	Y☐ / N☐	
8. Have you ever had any previous audiometric screening? Was this normal? State when and where.	Y☐ / N☐	
9. Have you ever had previous lung function screening? Was this normal? State when and where.	Y☐ / N☐	
10. Have you ever been rejected from employment on medical grounds?	Y☐ / N☐	
11. Have you ever received workplace compensation or is there any industrial claim pending?	Y☐ / N☐	
12. Have you ever been medivaced from an offshore installation?	Y☐ / N☐	
Examining Physician's comments:		

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Do you have or have you been diagnosed with or suffered from any of the following? [Please click on the box and elaborate]			
1.	Chest or heart pain or heart condition / palpitations / high blood pressure	Y☐ / N☐	
2.	Epilepsy / concussion / loss of consciousness / dizziness / stroke / paralysis	Y☐ / N☐	
3.	Ulcer / hernia / intestinal or abdominal disease (eg gall stones / change on bowel habit / haemorrhoids	Y☐ / N☐	
4.	Eye or visual problems / headaches	Y☐ / N☐	
5.	Kidney disease (e.g. stones / blood in urine)	Y☐ / N☐	
6.	Psychiatric disorder (e.g. anxiety, depression, psychosis)	Y☐ / N☐	
7.	Tuberculosis / hepatitis or other infectious diseases	Y☐ / N☐	
8.	Cancer	Y☐ / N☐	
9.	Problems coping with shift work	Y☐ / N☐	
10.	Alcohol or drug abuse or dependence	Y☐ / N☐	
11.	Sleep disorder (eg sleep apnoea syndrome)	Y☐ / N☐	
12.	Musculoskeletal conditions including bone or joint disorder, back problems?	Y☐ / N☐	
13.	Diabetes	Y☐ / N☐	
14.	Hearing difficulty or ear disease?	Y☐ / N☐	
15.	Asthma, shortness or other lung conditions	Y☐ / N☐	
16.	Do you take any medication? Please list:	Y☐ / N☐	
17.	Do you have any allergy (e.g. medication / bee stings etc)	Y☐ / N☐	
18.	Women -are you pregnant or breast feeding?	Y☐ / N☐	
19.	When was your last tetanus immunisation?	Date:	
20.	When did you last have a dental check?	Date:	Result:
21.	Do you exercise regularly (20-30 mins/ 3 days week/ any activity that makes you puff)?	Y☐ / N☐	
22.	Any other conditions not listed above?	Y☐ / N☐	
23.	Do any immediate family members (parents/brothers/sisters) have a history of any of the above conditions or any other condition?	Y☐ / N☐	

Further details:

I certify that the above information is correct:

Signed (candidate) Date

Physician's comments:

Systems review normal Y☐ / N☐

Medical Examination To be completed by Examining Physician

Chaperone: Declined ☐ Present ☐ ______________________

Photo ID	Passport No:	Driver's licence No:	Other:

Examination	Findings	Comments / Other exam
Pulse	/min Regular Y☐ / N☐	
Blood Pressure		
Heart sounds	S1+S2 Y ☐ / N ☐. Added N ☐ / Y ☐	
Murmurs	Absent Y ☐ / N ☐	
Oedema	Absent Y ☐ / N ☐	
Varicose Veins	Absent Y ☐ / N ☐	

Respiratory rate	/ min	
Breath sounds	Vesic Y☐ / N☐. Added N☐ / Y☐	
Percussion	Resonant Y☐ / N☐	
ENT	Normal Y☐ / N☐	
Teeth	Normal Y☐ / N☐	

Abdomen	Masses N☐ / Y☐	
Kidneys / Spleen	Normal Y☐ / N☐	
Liver	Normal Y☐ / N☐	
Hernias	Absent Y☐ / N☐	

Hands	Normal Y☐ / N☐	Able to:
Limbs	Normal Y☐ / N☐	Squat Y☐ / N☐ Bend Y☐ / N☐ Kneel Y☐ / N☐
Back	Normal Y☐ / N☐	
Joints	Normal Y☐ / N☐	
Injuries	Absent Y☐ / N☐	

Cranial nerves	I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐ VII ☐ VIII ☐ IX ☐ X ☐ XI ☐ XII ☐	
Tone	Normal Y☐ / N☐	
Power	Normal Y☐ / N☐	
Sensation	Normal Y☐ / N☐	
Coordination	Normal Y☐ / N☐	

Reflexes	Biceps	Triceps	Supinator	Knee	Ankle	Plantar
R						
L						

Ear drums	[R] Normal Y☐ / N☐				[L] Normal Y☐ / N☐			
(Hz)	500	1000	1500	2000	3000	4000	6000	8000
R								
L								

Visual acuity	Corrected:	[R]	[L]	[Together]
Distance	Uncorrected:	[R]	[L]	[Together]
Near Vision	Corrected:	[R]	[L]	[Together]
	Uncorrected:	[R]	[L]	[Together]
Visual fields Normal Y☐ / N☐	Colour vision Normal Y☐ / N☐		Fundi Normal Y☐ / N☐ Not Seen☐	

Height	Weight	Neck (cm)	Urine protein:	Sugar:	Blood:
Gait Normal Y☐ / N☐		Romberg's Normal Y☐ / N☐		Heel / Toe Coordination Normal Y☐ / N☐	

Mental state	Alert ☐ orientated ☐ mood ☐ affect ☐ thoughts ☐ insight ☐ perceptions ☐ problem solving ☐ memory ☐
Skin	Normal Y☐ / N☐
Other exam	
Drugs: Adulteration:	Temp: Test: COC ☐ Metamp ☐ OPI ☐ THC ☐ BDZ ☐ AMP ☐
Breath Alcohol:	
FEV1 (%pred)	FVC (%pred) PEFR FEV1:FVC Normal Y☐ / N☐
Stool culture (catering crew):	

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Physician comments:

Certification	Comment/Reason
Fit for offshore work as per Oil & Gas UK guidelines.	
Fit for restricted offshore work following discussion with operating company's medical adviser.	
Permanently unfit for offshore work	

Physician's signature:

Print name:

Date of Examination:

Dr Check:
History ☐ Exam ☐ Spiro ☐ Audio ☐ Lab ☐ Letter ☐ declined ☐ NA ☐ Tx,Ix,F/up discussed (incl joint decisions) ☐ Pt opp for questions ☐ All Complete ☐

Please either save and email to info@workhealthsolutions.co.nz or cick submit form to send it immediately. (You must be connected to the internet)