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**EMPLOYMENT SERVICES**

**MEDICAL STUDENT**

**WORK PLACE HEALTH ASSESSMENT FRONT SHEET**

Official Use only

|  |  |
| --- | --- |
| Applicants Name |  |
| Job Title | Medical Student |

**Once completed please return via email to** [**occhealth.referrals@mbht.nhs.uk**](mailto:occhealth.referrals@mbht.nhs.uk)

**or**

**Post to:**

**Occupational Health and Wellbeing Service**

**Southfield Unit**

**Royal Lancaster Infirmary**

**Ashton Road**

**Lancaster**

**LA1 4RP**

by **31st August 2023** after confirmation of your place.

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**Work Place Health Assessment for Medical Students**

Your answers to this questionnaire will be **CONFIDENTIAL** to the Occupational Health Department and will not be given to anyone else without your written permission. The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake the duties expected of a medical student during their training or place you at any risk whilst on clinical placement. We may recommend adjustments or assistance as a result of this assessment to enable you to fully engage with your medical education. Our aim is to promote and maintain the health of all people at work. You may be contacted by the Occupational Health Department and may need to be seen by an occupational health advisor or physician before health clearance is given for your studies and associated clinical placements.

Please help us to help you by completing the questionnaire as fully as possible.

|  |  |  |  |
| --- | --- | --- | --- |
| Title: Ms / Miss / Mrs / Mr / Mx / Dr / Professor: | | | |
| Surname/Family name: | | First name: | |
| Previous names (if applicable): | | | |
| Date of Birth: | | Course: **Medicine and Surgery** | |
| Course Lead/Tutor (if known): **Dr Martin Armer, Lancaster University** | | | |
| Have you ever worked/trained here OR Had a previous medical within Occupational Health? Yes  No | | | |
| Home Address: | | | |
| Post code: | Contact Number 1: | | Contact Number 2: |
| Email: | | | |
| Please indicate preferred method of contact | | Home Tel  Mobile  Letter | |

|  |  |
| --- | --- |
| Name of GP: | Tel No of GP: |
| Address of General Practitioner:  NHS No [Ask your GP for this 10 digit number]:   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  | | |

**PREVIOUS EMPLOYMENT IN THE LAST 5 YEARS**

|  |  |  |  |
| --- | --- | --- | --- |
| Employer | Nature of your work | Start date | Finish date |
|  |  |  |  |
|  |  |  |  |

**Please attach additional sheets of paper if necessary.**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| 1. Do you have any health conditions/illness/impairment/disability either physical or psychological? | Yes | No |
|  | | |
| If **yes**, please give details below |  |  |
|  | | |
| 1. Do you require any assistance/adaptations at work with regards to your health conditions/illness/impairment/disability? | Yes | No |
|  | | |
| If **yes**, please give details below |  |  |
|  | | |
| 1. Have you ever had any illness/impairment/disability which may have been caused or made worse by your work? | Yes | No |
|  | | |
| If **yes**, please give details below |  |  |
|  | | |
| 1. Do you have any allergies |  | |
| [e.g. latex, eggs, food or chemical substances, this is not exhaustive list so include any additional you consider relevant] | Yes | No |
|  |  | |
| If **yes**, please give details below |  | |
|  | | |
| 1. Are you having or waiting for treatment (including medication) or investigations at present | Yes | No |
|  |  | |
| If **yes**, please provide further details of the condition, treatment and dates |  | |
|  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Clinical diagnosis and management of tuberculosis, and measures for its prevention and control (NICE 2006)* | | | | | | |
|  | | | | | | |
| 1. Do you have any of the following: | | | |  | |  |
| 1. A cough which has lasted for more than 3 weeks? | | | | Yes | | No |
| 1. Unexplained weight loss? | | | | Yes | | No |
| 1. Unexplained fever? | | | | Yes | | No |
|  | | | | | | |
| 1. Have you lived continuously in the UK for the last 5 years? | | | | Yes | | No |
|  | | | | | | |
| 1. Have you visited or lived in a country for more than 4 weeks outside of the UK | | | | Yes | No | |
|  | | | |  |  | |
| **Country** | **Date From** | | **Date To** | | | |
|  |  | |  | | | |
|  |  | |  | | | |
|  |  | |  | | | |
|  |  | |  | | | |
|  |  | |  | | | |
|  |  | |  | | | |
|  | | | | | | |
| 1. Have you ever had a skin test (Mantoux, Heaf, Tine) in relation to TB | | | | Yes | No | |
|  | | | | | | |
| **If YES please provide the following information** | | | | | | |
| Date | | | |  | | |
| Result | | | |  | | |
|  | | | | | | |
| 1. Have you ever had a blood test (Quantiferon, T-Spot) in relation to TB | | | | Yes | No | |
|  | | | | | | |
| **If YES please provide the following information** | | | | | | |
| Date | | | |  | | |
| Result | | | |  | | |
|  | | | | | | |
| 1. Approx date of BCG vaccination or provide evidence from GP: | | | | Date | Evidence | |
| **If DATE has been ticked please provide the following information** | | Date | |  | | |
|  | | | | | | |
| 1. Do you have a BCG Scar | | | | Yes | No | |
|  | | | | | | |
| 1. Have you ever had a chest X-ray in relation to TB | | | | Yes | No | |
|  | | | | | | |
| **If YES please provide evidence** | | | |  |  | |
|  | | | |  |  | |
| 1. Have you ever had TB or Latent TB | | | | Yes | No | |
|  | | | |  |  | |
| **If YES please give details and provide evidence of treatment** | | | |  |  | |
|  | | | | | | |

**Immunisation record**

**Have you had the following immunisations, vaccinations or blood tests?**

**If you answer YES to any of the below you will need to obtain documented evidence from your GP or previous employer, where possible please**

|  |  |  |  |
| --- | --- | --- | --- |
| Tetanus | | Yes | No |
| Polio | | Yes | No |
| Diphtheria | | Yes | No |
| Whooping Cough (Pertussis) | | Yes | No |
|  | | | |
| Measles | | Yes | No |
| Mumps | | Yes | No |
| Rubella | | Yes | No |
| MMR | | Yes | No |
| **If yes please provide the following information** | **Dose 1** | **Date** |  |
| **Dose 2** | **Date** |  |
|  | | | |
| Meningitis C | | Yes | No |
| Meningitis ACWY | | Yes | No |
|  | | | |
| Varicella Vaccination | | Yes | No |
| Have you had Varicella (Chickenpox or Shingles) | | Yes | No |
| Can you provide serological evidence (Blood test) | | Yes | No |
| Where you born or raised overseas | | Yes | No |
| **If yes please provide the following information** | | **Where** |  |
|  | | | |
| Hepatitis A | | Yes | No |
|  | | | |
| Hepatitis B | | Yes | No |
| **If yes please provide the following information** | **Dose 1** | **Date** |  |
| **Dose 2** | **Date** |  |
| **Dose 3** | **Date** |  |
| **Dose 4** | **Date** |  |
| **Booster** | **Date** |  |
|  | | | |
| Hepatitis B Immunity Blood Test | | Yes | No |
| **If yes please provide the following information** | | **Result** |  |
|  | | **Date** |  |

|  |  |  |
| --- | --- | --- |
| **ALL MEDICAL STUDENTS MUST COMPLETE THIS PAGE.**  **PLEASE READ THE INFORMATION BELOW**  **NB** This does **not** include procedures such as Venepuncture | | |
| As you may be aware, recent Department of Health Guidelines require testing for Hepatitis C, HIV and Hepatitis B surface antigen for all staff that are entering training rotations that involve exposure prone procedures (invasive procedures). Exposure Prone Procedures (EPP) are those procedures where the worker’s gloved hands may be in contact with sharp instruments, needle tips or sharp tissue (e.g. spicules of bone or teeth) and inside a patient’s open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times.  **These tests are COMPULSORY for all medical students.** If, therefore, you have not been tested previously this must be carried out before you will be allowed on clinical placement. If necessary, all relevant blood tests will be arranged via the Occupational Health Department as part of the health screening procedure.  This must be an identified validated sample (IVS). Health clearance for EPP work cannot be given until these results have been received and processed by the Occupational Health Team. **IF YOU HAVE PREVIOUS BLOOD RESULTS AND / OR DOCUMENTED EVIDENCE OF RELEVANT VACCINATIONS PLEASE SUPPLY A COPY WHEN YOU SUBMIT THIS FORM.**  May we take this opportunity to remind medical students that, as future healthcare professionals, if you know yourselves to be at high risk of exposure either currently or in the past under whatever circumstances, or indeed know yourself to be a carrier, you have an ethical & legal duty of care to patients to inform Occupational health, in confidence, as defined in your Code of Professional Conduct:  <http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp>  **IF RESULTS ARE NOT AVAILABLE YOU WILL BE TESTED IN THIS DEPARTMENT AND HEALTH CLEARANCE FOR EPP WORK WILL BE DELAYED UNTIL THESE RESULTS ARE PROCESSED.**  **This is to comply with the Department of Health’s standard for Identified Validated samples (IVS).** | | |
|  | Yes | No |
| **Will you be performing Exposure Prone Procedures (please read paragraph above**) |  |  |
| **Have you included IVS evidence of HIV test?** |  |  |
| **Have you included IVS evidence of Hepatitis B Surface Antigen test?** |  |  |
| **Have you included IVS evidence of Hepatitis C test?** |  |  |

**DECLARATION**

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.

I give permission for a member of the Occupational Health Department to communicate with my own general practitioner, or any other health professional, if further information is required and for that GP or healthcare professional to give details of my clinical condition or other relevant information to the OH advisor/physician at the Occupational Health Department.

I understand that I shall be contacted to obtain my fully informed consent **before** any report is requested and that under the Access to Medical Reports Act, 1988:

* I have the right to see the report before it is sent.
* I am entitled to ask the doctor to amend or modify information which I consider is inaccurate.
* I have 21 days from notification to seek access to the report.

\*I wish to seek access to this report/I do not wish to seek access to this report

I agree to undertake any health surveillance, if required, in the future.

I am aware that the Occupational Health Advisor will advise Lancaster Medical School of the outcome of this health assessment, including advice on fitness for training and / or recommendations, such as, reasonable adjustments, if necessary. I understand that limited and appropriate medical information may need to be disclosed to Lancaster Medical School, under certain circumstances (such as when reasonable adjustments are required), and that my consent will be obtained should this be required.

I understand that withholding consent will prevent me from being allowed on clinical placement and will delay or prevent the implementation of reasonable adjustments.

I understand that any failure to disclose medical information affecting my ability to participate in clinical placements may lead to the offer of a place to study medicine being withdrawn.

|  |  |
| --- | --- |
| Signed | Date |

**Final check list before sending**

Please ensure the following are completed / enclosed, failure to do so may result in delayed health clearance or temporary restrictions

|  |  |  |
| --- | --- | --- |
| Have you attached or are you sending documented evidence of your vaccinations, immunisations and blood tests | Yes | No |
|  |  |  |
| If you have answered yes to the above please state how you are sending this evidence | Post |  |
| In person |  |
| Attached |  |

**All information given to the Occupational Health Department is, of course, held in strictest confidence and held on a secure trust database that is only accessible by occupational health staff. Thank you for your help in this matter.**