|  |
| --- |
| Under the Working Time Regulations (1998) and Amendment Regulations (2003) night workers are entitled to regular health assessments. This questionnaire is confidential and will be used by the Occupational Health Service to assess your health in relation to night work.The completed questionnaire should be returned directly to the Occupational Health Service. Employeesperforming night work may be advised to attend for a consultation depending on the results of the questionnaire.  |
| **Name** |       |
| **Date of Birth** |       |
| **Service** |       |
| **Tel No.** |       |
| **Type of Night Work****(please tick)** | Continual Night Work | [ ]  | Rotating Shift Pattern | [ ]  | Occasional Night Work | [ ]  |
|  |
| **Please answer each question by ticking “YES” or “NO”.** | **Yes** | **No** |
| 1. | Do you take any prescribed medication on a regular basis? | [ ]  | [ ]  |
| 2. | Do you suffer from Insulin dependent diabetes? | [ ]  | [ ]  |
| 3. | Do you suffer from epilepsy? | [ ]  | [ ]  |
| 4. | Do you suffer from a sleep disorder? | [ ]  | [ ]  |
| 5. | Do you suffer from depression? | [ ]  | [ ]  |
| 6. | Do you suffer from stomach or duodenal ulcers? | [ ]  | [ ]  |
| 7. | Do you suffer from heartburn or indigestion? | [ ]  | [ ]  |
| 8. | Do you, or have you ever suffered from any heart problems? | [ ]  | [ ]  |
| 9. | Are you pregnant, or are you a nursing mother? | [ ]  | [ ]  |
| 10. | Do you suffer from any health problem which you feel is affected by night work? | [ ]  | [ ]  |
| If you have answered “YES” to question (1), please give details of any regular medication below |
| **Medication** | **Dose** | **Time Taken** |
|       |       |       |
|       |       |       |
|       |       |       |
|  |
| If you have answered “YES” to any of these questions you may be contacted for further information by one of the Occupational Health staff or asked to attend a consultation to further assess your fitness for night work.

|  |
| --- |
| If required what would be a suitable time to make contact with you. |

This questionnaire will be retained in your Occupational Health records. I understand that the medical information provided is confidential but that the outcome of the assessment in terms of a statement on fitness for post will be passed on to my employer. |
|  |
| **Signed** |  |  |  | **Date** |       |
| **Print Name** |       | **Date of Birth** |       |
|  |
| For Occupational Health Use Only |
| **Result** |
|  |
| FIT | [ ]  |
| REFER TO MEDICAL ADVISOR | [ ]  |
|  |
| Reason for referral to medical advisor (for Medical Advisor referral information) |
|       |
|  |
|  |
| Signature of OHN |  |  | Date |       |  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |