Responsible Person Health Surveillance

Employee Name:	
Employee Number:	
Site Number for Current Assessment:	

Health Surveillance	**Date of Last Health Surveillance (If Any)**	**Required on this occasion?**	**Date completed on this occasion (or enter N/A)**	**Referral to General Practitioner**
Hand-Arm Vibration Syndrome		☐ Yes ☐ No		☐ Yes ☐ No
Skin		☐ Yes ☐ No		☐ Yes ☐ No
Respiratory		☐ Yes ☐ No		☐ Yes ☐ No

The attached questionnaires should only be used by a responsible person

This front sheet is for administrative purposes and should be completed and attached to the questionnaire.

This Interim Health Surveillance Questionnaire is suitable for existing employees and the newly employed.

Above you will find a table indicating the last time health surveillance took place and which assessments were required on this occasion.

Once you have completed your assessment as the responsible person, please complete the table and keep this record in accordance with Data Protection.

The purpose of this questionnaire is to evaluate the adequacy of controls and to protect your health by early detection of any adverse health effects. This questionnaire should be completed by all employees who are deemed, by risk assessment, to require health surveillance for any or all of the following:

Health Surveillance required	Yes	Relevant exposure(s)
Hand-Arm Vibration Syndrome	☐	
Skin	☐	
Respiratory	☐	

Once completed it will be retained as part of your health record in your personnel file throughout your employment, with access restricted under the Data Protection Act 1998.

It is important that you are accurate with the answers to these questions. When you declare **NO**, you are accepting a degree of responsibility for your own health and safety at work.

If further assessment is required, you will be asked to be reviewed by an Occupational Health professional (nurse or doctor).

Personal Information

Last name:		Title:	
First names:		Male ☐	Female ☐
Date of birth:	Tel no:	Mob no:	
Job Title:	Manager:		
Address:			
Postcode:	National Ins. no:		
Email :			

Occupational History

Please complete the table below detailing your current job, all job types that you have had previously, and hazards that you were exposed to, with approximate start and finish dates.

Dates	Job Title	Company	Hazards
e.g. 2001- 2006	*Mechanic*	*ABC Motors*	*Noise, dust, fumes, chemicals and vibrating tools.*

Name:	**DOB:**	**Job Title:**

HAND-ARM VIBRATION SYNDROME (HAVS) INTERIM HEALTH SURVEILLANCE

	Yes	**No**
Have you ever been diagnosed with Hand-Arm Vibration Syndrome (HAVS) or Vibration White Finger (VWF) at a previous assessment?	☐	☐

If **YES**, you may require further assessment by an Occupational Health professional but you should complete the questions below, sign the form and return it to the responsible person.

	Yes	**No**
Have you used hand-held vibrating tools, machines, or hand-fed processes in your job since your last assessment?	☐	☐

If **NO**, or more than 2 years since last exposure, please sign the form and return it to the responsible person. If **YES**, please complete the following questions:

		Yes	**No**
1.	Do you have any numbness or tingling of the fingers which lasts for more than 20 minutes after using vibrating tools?	☐	☐
2.	Do you have numbness or tingling of the fingers at any other time?	☐	☐
3.	Do you wake at night with pain, tingling, or numbness in your hands or wrists?	☐	☐
4.	Have any of your fingers gone white* on exposure to cold? **whiteness is a clear discolouration of the fingers with a sharp edge, usually followed by a red flush.*	☐	☐
5.	Have you noticed any change in your response to your tolerance of working outdoors in the cold?	☐	☐
6.	Are you experiencing any other problems in your hands or arms?	☐	☐
7.	Do you have difficulty picking up very small objects, e.g. screws or buttons or opening tight jars?	☐	☐
8.	Has anything changed about your health since the last assessment?	☐	☐

I certify that all the answers given above are true to the best of my knowledge and belief.

Signed: .... **Date** ....

To be completed by the Responsible Person:

	Yes	**No**
Further action required?	☐	☐
Refer to Occupational Health?	☐	☐

Comments:

I have discussed the outcome with the employee and noted any employee concerns in the comments section above.

Name of Responsible Person: ....

Signature: .... **Date** ....

Name:	DOB:	Job Title:

SKIN INTERIM HEALTH SURVEILLANCE

	Yes	No
Have you ever been diagnosed with work-related or occupational dermatitis at a previous assessment?	☐	☐

If **YES**, you may require further assessment by an Occupational Health professional but you should complete the questions below, sign the form and return it to the responsible person.

	Since your last review or in the last 12 months have you had any of the following symptoms:	**Yes**	**No**
1.	Redness or irritation of fingers or hands?	☐	☐
2.	Flaking or scaling of the skin on fingers or hands?	☐	☐
3.	Cracking of the skin on fingers or hands?	☐	☐
4.	Blisters on fingers or hands?	☐	☐
5.	Itching of fingers or hands?	☐	☐
6.	Have you lost time from work with a skin problem?	☐	☐
7.	Have you seen your GP for a skin problem?	☐	☐
8.	Have you been diagnosed with a skin problem?	☐	☐

I certify that all the answers given above are true to the best of my knowledge and belief

Signed: .... **Date:** ....

To be completed by the Responsible Person:

	Yes	No
Are moisturisers/barrier creams used?	☐	☐
Are gloves worn when required?	☐	☐
Visible skin problems today?	☐	☐
If pre-existing skin problem, has there been any change?	☐	☐
Further action required?	☐	☐
Refer to Occupational Health?	☐	☐

Comments:

I have discussed the outcome with the employee and noted any employee concerns in the comments section above.

Name of Responsible Person: ....

Signature: .... **Date:** ....

Name:	DOB:	Job Title:

RESPIRATORY INTERIM HEALTH SURVEILLANCE

	Yes	No
Have you ever been diagnosed with work-related or occupational chest problem (such as asthma) at a previous assessment?	☐	☐

If **YES**, you may require assessment by an Occupational Health professional, but you should complete the questions below, sign the form and return it to the responsible person.

	Since your last review or in the last 12 months have you had any of the following: (do not included isolated colds, sore throats, flu or hayfever)	**Yes**	**No**
1.	Wheezing?	☐	☐
2.	Chest tightness?	☐	☐
3.	Breathlessness?	☐	☐
4.	Cough?	☐	☐
5.	Blocked or runny nose?	☐	☐
6.	Soreness and/or watering of eyes?	☐	☐
7.	Have you seen your GP for chest problems?	☐	☐
8.	Have you taken any treatment for your chest?	☐	☐
9.	Have you ever been told by a doctor that you suffer from asthma?	☐	☐
10.	Do you smoke?	☐	☐

I certify that all the answers given above are true to the best of my knowledge and belief.

Signed: ______________________ **Date** ______________________

To be completed by the Responsible Person:

	Yes	No
Is Respiratory Protective Equipment (RPE) required?	☐	☐
If so, is Respiratory Protective Equipment (RPE) used?	☐	☐
Further action required?	☐	☐
Refer to Occupational Health?	☐	☐

Comments:

I have discussed the outcome with the employee and noted any employee concerns in the comments section above.

Name of Responsible Person: ______________________

Signature: ______________________ **Date:** ______________________