OCCUPATIONAL HEALTH UNIT

# NIGHT WORKERS HEALTH QUESTIONNAIRE

## OCCUPATIONAL HEALTH UNIT
## Ground Floor, Building 4, St David's Park, Jobswell Road, Carmarthen, Carmarthenshire, SA31 3HB

The purpose of this questionnaire is to monitor your health in relation to night working duties. The Working Time Regulations 1998 require the Council to provide night workers with the opportunity of a free health assessment. This questionnaire has been designed to provide this facility.

**Please complete the health assessment form, be assured that all the information you provide will be kept confidential.**

| MANAGER DETAILS | | | |
|---|---|---|---|
| **Referring Manager:** | | | |
| **Workbase:** | | **Telephone:** | |
| **E-mail:** | | **Date:** | |
| **HR Officer:** | | **Tel No:** | |
| **COST CODE**: ***Referrals will not be accepted without this information*** | | | |

| EMPLOYEE DETAILS | | |
|---|---|---|
| **Title** | **First Names** | **Surname** |
| **Mr/Mrs/Miss/Ms** | | |
| **Date of Birth** | **Home Address** | **Telephone Number** |
| | | |
| **Job Title** | **Department** | **Workbase** |
| | | |
| **Division** | **Extension Number** | **Employee Number** |
| | | |
| **Start Date** | **DURATION OF NIGHT WORK (HOURS)** | |
| | | |

Please answer the following questions to the best of your knowledge. If you answer yes to any of the following questions a further medical assessment may be required, however, this does not necessarily mean that you are unfit for night work.

| **Do you currently suffer from or within the past 5 years have you ever had any of the following? If so, please give details**:- | | |
|---|---|---|
| Diabetes | Yes | No |
| Heart or Circulation Disorders | Yes | No |
| Stomach / Intestinal Disorders | Yes | No |
| Any condition which causes difficulty in sleeping | Yes | No |
| Chronic chest disorders, especially if night time symptoms are troublesome | Yes | No |
| Any medical condition requiring medication to a strict timetable | Yes | No |
| Any other health factors that might affect fitness | Yes | No |
| Are there any conditions / disorders not declared above that you wish to discuss with the Occupational Health Adviser / Nurse? | Yes | No |

If you have answered 'Yes' to any of the above questions, you will receive a phone call from an Occupational Health Nurse/Advisor who will request further information. You may be asked to attend an appointment at the Occupational Health Unit.

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**EMPLOYEE**

I, the undersigned, confirm that the above information is correct to the best of my knowledge.

Print Name (Block Capitals):_____

Signed: _____ Date: _____

**PLEASE RETURN THIS NIGHT WORKERS HEALTH QUESTIONNAIRE TO THE OCCUPATIONAL HEALTH UNIT IN THE ENVELOPE PROVIDED**

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**OCCUPATIONAL HEALTH NURSE**

Print Name: _____

Signed: _____

Date: _____