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Community and Mental Health Services

OCCUPATIONAL HEALTH DEPARTMENT

Health Assessment Questionnaire for Night Workers

The Trust is obliged to offer staff a health assessment before they start working nights and on a regular basis whilst they work or rotate onto nights. Individual members of staff are not obliged to complete this questionnaire if they do not want to. Workplace hazards are unlikely to change during night time; risk may become greater where individuals are suffering from certain medical conditions which could be aggravated by night work.

Definition of a Night Worker
A night worker is any worker whose daily working time includes at least 3 hours at night. Night time is between 11pm and 6am. Nightly working time is calculated over a 17 week period.

Completion of the questionnaire is voluntary for staff. If the information requested below is incomplete it will not be accepted in the Occupational Health Department.

EMPLOYEE DETAILS (PLEASE PRINT)

TITLE	Dr/Mr/Mrs/Ms/Miss/Other	**SURNAME**		
FIRST NAMES				
D.O.B		**GENDER**	**M**	**F**
HOME ADDRESS & POSTCODE: (this is required for feedback)				
TEL NUMBER (HOME)				
MOBILE				

MANAGER NAME:				
EMPLOYMENT DETAILS:				
JOB TITLE/DESCRIPTION				
F/T	**P/T**	**PERMANENT**	**TEMPORARY**	**FIXED TERM**
TYPE OR PATTERN OF NIGHTS;ROTATING SHIFTS (how many nights, how long, how often) Please also state if have a specific contract for night working				
ANY SPECIAL OCCUPATIONAL HAZARDS OR FEATURES OF THE JOB:				

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Your answers do not have to be seen by your manager and Occupational Health will not disclose any medical details to them. They will however advise your manager if you are fit or unfit for night work. Your questionnaire will be used by occupational health to decide if you should be offered further (voluntary) health checks to protect your health at work.

Please tick yes or no in answer to the questions. There is also space provided to include any additional information about your health that you think is relevant to night work.

Do you suffer from:

1	Diabetes?	Yes	No
	Is your condition controlled by: insulin	Yes	No
	tablets	Yes	No
	diet	Yes	No
2	A heart or circulatory problem?	Yes	No
3	Any digestive disorder, e.g. ulcer, or any condition where the time of a meal is particularly important?	Yes	No
4	Any medical condition that causes difficulty sleeping?	Yes	No
5	Any chest disorder where night time symptoms are experienced?	Yes	No
6	Any medical condition requiring medication on a strict timetable?	Yes	No
7	Anxiety, depression or any mental illness?	Yes	No
8	Any other symptoms or medical condition that may affect your fitness to work nights?	Yes	No

If you have answered Yes to any of the questions on the previous page please provide more information about your condition:

Additional comments

NB If your health deteriorates between completion of questionnaires, please feel free to contact the Occupational Health Department on 0151 471 2451.

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If this is being sent by post to the Occupational Health Department please sign and date it. This is not required if it is being e-mailed from your e-mail account. Declaration: I declare that my answers to the questions on this form are true and complete.

Signed: **Name:** **Date:**

When you have completed the form it should be returned directly to the Occupational Health Department, Switch House, Northern Perimeter Road, Bootle, Merseyside L30 7PT or e-mailed to the Occupational Health Department on occupationalhealth@merseycare.nhs.uk

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FOR OCCUPATIONAL HEALTH USE ONLY Questionnaire clearance only
Telephone Call: Health Interview with:

Date: Doctor: Nurse