MEDICAL IN CONFIDENCE

Initial screening questionnaire for employees using Chemicals

**RETURN IN CONFIDENCE TO: XXXXXXXXXXX**

(Responsible person, not necessarily medically trained)

Use the findings of this questionnaire to decide what else, if anything, needs to be done. Any report of health effects may be referred to a trained assessor or registered medical practitioner for further clinical investigation (they may need to report it under RIDDOR). Findings may result in temporary restriction of chemical or equipment use, to remove the worker from further exposure pending diagnosis.

It is not usually necessary to refer those who do not report symptoms, but you should keep records and seek every opportunity to minimise chemical exposure.

To be completed by the MD or their nominated person and employee.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emp; №: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1.1. Brief description of the nature of your work/risks, i.e. have you been exposed to chemicals, cement products or any other hazardous materials/environments?

1.2 Do you undertake any hobbies or out of work activities which may bring you into contact with hazardous chemicals, materials or environments? Y/N (If yes please specify)

1.3 Have any of your immediate family members experienced skin conditions which impacted on their ability to work? YES/NO (If yes please specify)

1.4 Are you currently receiving any medical treatment/topical applications prescribed un/prescribed from your G.P., hospital or pharmacy for a skin condition?YES/NO

 (If yes please specify)

1.5 Do you currently have or have you ever suffered from a skin condition such as eczema, dermatitis, hives, psoriasis or any skin problems/conditions that you or your doctor has identified? (If ‘yes’ please complete section 2, if ‘no’ go to Declaration).

 YES/NO

2.0 Have you had or have at present any of the following?

 1. Spots/rash/redness or swelling of fingers or hands YES/NO

 2. Cracking of skin on fingers or hands YES/NO

 3. Blisters on fingers or hands YES/NO

 4. Flaking or scaling of skin on fingers or hands YES/NO

 5. Itching of fingers or hands with cracks or splits YES/NO

 6. Any changing appearance of existing moles/warts/skin blemishes YES/NO

 7. Any other parts of the body affected by skin conditions YES/NO

 8. Any other skin blemished or skin conditions that you are concerned about YES/NO

2.1 Have you ever taken time off work due to a skin condition? YES/NO

2.2 Did the skin condition last for more than three weeks and/or recurring in nature? YES/NO

2.3 Does the skin condition get better with time off work? YES/NO

2.4 Have you ever lost time off work with a skin problem? YES/NO

2.5 Do you know the cause of the skin problem? (If yes please specify) YES/NO

2.6 Do you know the substance/material/contact agent that you think may be responsible? YES/NO

 (Please consider any substances/materials/contact agents used at home)

2.7 Please indicate on the diagram below areas affected on hands (if applicable)

If you have answered ‘yes’ to any question in Section 2 please provide details below:

Details below

3.0 Are you aware of the availability of P.P.E. (Personal Protective Equipment) and been advised/provided with appropriate P.P.E. for your job functions? YES/NO

 (If no please specify)

3.1 Are you aware of the COSHH (Control of Substances Hazardous to Health) Regulations data sheet regarding the specific substances which you are in contact with during the course of your employment? YES/NO (If no please specify)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.2 Are you aware of and currently using the skin management products provided by the company? YES/NO

 (If no please specify)

* + Pre work barrier creams YES/NO
	+ Soaps YES/NO
	+ Reconditioning cream YES/NO

4.0 Action plan for skin management

4.1 Have any skin related problems been identified? YES/NO

4.2 Advice has been provided as follows:

* + Use of Personal Protective Equipment YES/NO
	+ Availability of COSHH data sheets YES/NO
	+ Skin management/good hygiene regime YES/NO

4.3 Referral to:

* + Company Occupational Health doctor YES/NO
	+ Own G.P. YES/NO

4.4 Advice given to:

* + Health and Safety Manager YES/NO
	+ Supervisor YES/NO

4.5 Current restriction on duties: □ No □ Yes for a period of \_\_\_\_\_\_\_ weeks/months

4.6 Review required: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.7 Further action:

Declaration:

I certify that the answers to the above questions are correct to the best of my knowledge. I understand that if I have withheld information, this may adversely affect the control measures required to safeguard myself whilst undertaking certain job functions. Further more; I am aware that I am required to report any injuries, symptoms or health concerns which may affect my work to either my supervisor or the Occupational Health Department as soon as possible.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational Health Nurse Advisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_