

**Pre-Placement Health Assessment**  
**NHS Tayside Occupational Health**  
Wedderburn House, 1 Edward Street, Dundee DD1 5NS  
Tel 01382 346030

**Universities of Abertay, Dundee and St Andrews (ScotGEM)**  
**Perth College and Dundee & Angus College**

**Candidate:** Please ensure that you **fully** complete sections **A** to **B**. **Only** complete section **C** if you have a health condition that may impact on your studies or placements.

**Section A**

**Course Details**

Name of candidate:

DOB

**Course:**

- Medical
- Dental
- Nursing
- Year 1 Foundation Apprenticeship
- Year 2 Foundation Apprenticeship
- Access to Nursing
- HNC Care & Admin
- Post Grad  please specify
- MSc Human Clinical Embryology and Assisted Conception
- Other – please specify

Please tick which University / College you will be attending

- University of Abertay
- University of St Andrews & Dundee(ScotGEM)
- University of Dundee  Tayside / Fife Campus(delete as appropriate).
- Perth College
- Dundee & Angus College

**Section B:**

**Personal and Contact Details**

First name

Second name

Previous name if any

Date of birth

Gender (please circle)    Male            Female            Other (please state)

Contact address

Contact telephone number (home)

Contact telephone number (mobile)

*where provided this number will be used to send you SMS texts to remind you of your OH appointments*

Contact e-mail address

*where provided this email address will be used to send you your OH appointments*

Have you been seen by Tayside Occupational Health before? If YES please state when and a brief description why

Please give details of absences you have had (if any) from employment/education over the last two years and the reasons for these

| Lifestyle  |  |
|--|--|
| How many units of alcohol do you drink in an average week? (1/2 pint beer = 1 unit, 1 glass wine = 1 unit) |  |
| Have you ever smoked? Yes <input type="checkbox"/> No <input type="checkbox"/>                             | Do you still smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| How many cigarettes etc per day?   |  |
| Height (without shoes):  | Weight (unclothed):  |

| COVID Risk Assessment   |  |
|---|--|
| Have you ever been identified as being required to shield from COVID and/or consider yourself as being at high risk from COVID? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If <b>yes</b> provide details   |  |
|   |  |

| Skin or breathing problems and allergies – please give full details if you answer YES to any question  |  |  |
|--|--|--|
| Do you have, or worry that you may have a latex allergy (natural rubber)?<br><br><i>You may have an allergy if you have developed a rash, swollen lips, or had difficulty breathing etc when you have used latex products in the past e.g. blowing up balloons, using washing up gloves etc.</i> | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| Are you allergic to certain foodstuffs e.g. bananas, kiwi, chestnuts, avocados etc? If yes, please give details.   | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| Do you have, or have you had asthma or other breathing problems in the past?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |

| <b>Skin or breathing problems and allergies – please give full details if you answer YES to any question</b> |  |  |
|--|--|--|
| Do you have any ongoing, or recurrent skin problems e.g.eczema/dermatitis/psoriasis?                         | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| Do you have any other allergies?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |  |

| <b>Tuberculosis(TB) screening</b>   |  |
|---|--|
| Have you had any of the following:  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <ul style="list-style-type: none"> <li>• TB immunisation (BCG)</li> <li>• Mantoux test/ interferon gamma release assay (IGRA)/T-Spot or Quantiferon</li> </ul>    | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <b><i>If YES to one or more of the above please provide written evidence (you may be able to obtain this from your GP or previous OH provider).</i></b>           |  |
| Have you lived or worked outside of the UK in the last 5 years, or been abroad for 12 weeks or longer in that time?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If you answered YES to the above which countries have you lived in/visited and for how long in each country?  |  |
| Have you ever had tuberculosis (including 'latent TB') in the past?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If YES when and where did you have treatment? (please send us any written confirmation of past treatment if you have this from the organisation that treated you) |  |
| Have you had a chest x-ray?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If YES to the above where and when was the X-ray taken and what was the result?   |  |

| <b>Tuberculosis(TB) screening</b>   |  |
|---|--|
| Have you been in close contact with anyone who has had TB?                              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you had a persistent or recurring cough?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you coughed up blood?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you had any night sweats e.g. have had to change bedclothes/nightwear as a result? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you had any unexplained weight loss?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you noticed any other symptoms that have concerned you?                            | Yes <input type="checkbox"/> No <input type="checkbox"/> |

| <b>Immunisation details</b>  |
|--|
| <p>Have you had Chickenpox / Shingles?      Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>To prevent the transmission of communicable diseases all healthcare workers (HCWs) including Health Care Students are encouraged be immunised/demonstrate immunity to the following conditions:</b></p> <p style="text-align: center;">Chickenpox   Measles   Mumps   Rubella   Hepatitis B   COVID-19</p> <p>You may have been immunised against all or some of these conditions by your GP and/or previous OH provider, if <b>so please provide written evidence from the relevant provider.</b></p> <p>If required OH will offer you an immunisation consultation/update on commencement of your training course</p> <p><b>Please note</b><br/>It would be helpful if the university/placement provider has knowledge of your immunisation status to help them safeguard your health and that of patients.</p> <p><b>Please tick the box if you give your consent for your immunisation details to be shared. <input type="checkbox"/></b></p> |

**Exposure prone procedure work (EPP)**

Please complete this section if your job is likely to mean that you might be required to perform, or assist at surgery; obstetric procedures; dentistry; A&E trauma work; podiatry etc or any other invasive clinical procedures where your hand/fingers might be placed in a patient's open body cavity.

Date first commenced EPP work?

Have you had any breaks of service from the NHS since first clearance?

Yes  No

If Yes please provide details of duration and reason for break

Have you any reason to suspect that your ability to undertake EPP work has changed e.g. post-needlestick incident and further testing is required?

Yes  No

If YES, NHS Tayside Occupational Health will arrange this for you

**If you have been previously EPP cleared we require evidence that previous blood tests were Identified Validated Samples (IVS) which must be obtained from your current Occupational Health (OH) Provider. If available please append that information to this questionnaire. If you are unable to provide this we will offer you an appointment.**

**Offer of testing for blood borne viruses to Non-EPP Workers**

As a new healthcare worker we can offer confidential testing for blood borne viruses i.e. Hepatitis B, Hepatitis C and HIV, even if you do not require to be tested as a requirement for your job. The results of these will not be shared with anyone else without your permission.

On commencement if you wish to be seen for the above please contact Tayside Occupational Health.

### Declaration of an underlying health condition or disability

Please ensure that you have read the accompanying occupational health information sheet that gives examples of when a declaration of an underlying health condition, or disability might be relevant to you **before** you select one of the two statements below.

Please **read both** statements below and then choose **one** (by ticking box) that best reflects your understanding of your current or past health.

#### Statement 1

**I am not aware of any health condition(s) or disability which might impair my ability to undertake effectively the duties of the position I have been offered.**

If you have selected this option, please sign the declaration at the bottom of this page. You have now **finished** this pre-placement questionnaire (you **do not** need to complete **Section C**).

#### Statement 2

**I do have a health condition or disability which might affect my work and may require special adjustments to my work or at my place of work.**

If you have selected this option, please sign the declaration below **AND** complete **Section C** on the next page.

I declare that I have answered all questions honestly and completely to the best of my knowledge and I am not aware of any physical / mental or other medical condition which would affect my ability to perform the duties of the above post.

I understand that failure to disclose relevant health details may jeopardise my future employment with NHS Tayside.

Date \_\_\_\_\_ Signature \_\_\_\_\_

