**Staff working with Respiratory Sensitisers – Three / Six month Assessment**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname: |  | Mr / Mrs / Miss / Ms / Dr / Prof | |
| First names: |  | Date of Birth |  |
| Job Title |  | Department |  |

**1. Work Information**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Which respiratory sensitisers are you working with? | | |  | |
| How many hours per week (on average)? | |  | | |
| What control measures are in place, *e.g. fume cupboard, LEV etc?* | | | |  |
|  | | | | |
|  | | | | |
|  | | | | |
| What PPE is worn? |  | | | |
|  |  | | | |
|  | | | | |

**2. Symptoms**

Have you experienced any of the following symptoms since your initial health assessment?

*Do not include isolated colds, sore throats, flu or chest infections.*

|  |  |
| --- | --- |
| Recurring blocked or running nose | Yes  No |
| Sneezing attacks | Yes  No |
| Watery, itchy eyes | Yes  No |
| Persisting or recurring cough | Yes  No |
| Chest tightness or shortness of breath | Yes  No |
| Episodes of wheezing | Yes  No |
| Skin rashes, dermatitis or eczema | Yes  No |

**3. Declaration**

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

|  |  |  |  |
| --- | --- | --- | --- |
| Signed: |  | Date: |  |

|  |
| --- |
| **For OH use only** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | Age: |  | Height |  |
| Dept: |  | Date/time |  | | |

**Skin:**

|  |  |
| --- | --- |
| Dermatitis: | General condition: |
| Gloves used: | |

**Discussion notes:**

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**Advice given:**

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| --- |
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|  |

**Outcome:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Spirometry – within normal parameters | | | | | Yes  No |
| Suitable to continue working with respiratory sensitisers | | | | | Yes  No |
| Routine 6 month surveillance | | | | | Yes  No |
| Routine annual surveillance | | | | | Yes  No |
| Discuss with SOHA *(NB. Any +ve symptoms / concerns must be discussed with SOHA)* | | | | | Yes  No |
| Refer for face fit mask test | | | | | Yes  No |
| OHP file review | | | | | Yes  No |
| OHP assessment | | Yes  No | | OHP assessment arranged | Yes  No |
| Enhanced health surveillance *(Please specify)* | | | | | |
| 3 months | 6 months | | 12 months | | |
| other *(Please specify)* |  | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Clinic nurse / OHA signature: |  | Print name / stamp: |  |

Surname

First Name(s) Date of Birth Sex

Job title

Contact number(s)

Email

Date / time

**OCCUPATIONAL HEALTH RECORD**

**CONTINUATION SHEET**

Supervisor

Contact details

GP