NORTHERN STAR
RESOURCES LIMITED

PRE-EMPLOYMENT MEDICAL FORM

NSR SUMMARY			
Surname		First Name	
Position		Company / Facility	

*Applicant to complete pages 3-8

WORK FITNESS RECOMMENDATIONS [1 2 **]

- ☐ **GREEN**
  - ☐ Suitable for Proposed Position – unconditional.
  - ☐ Suitable for Proposed Position – conditional. See Details below
    - ☐ Medical follow up (nonurgent)____________________________
      - ☐ Letter to GP Provided
- ☐ **AMBER –** Suitable for the proposed position subject to;
  - ☐ OHS assessment of functional test results
  - ☐ OHS / HR assessment of **risks identified** (see below comments box for identified risks)
  - ☐ Modifications and restrictions required (see below)
  - ☐ BMI equal to OR greater than 40
  - ☐ Concerning behaviour
- ☐ **RED –** Not suitable for the proposed position
  - ☐ High risk of aggravating a pre-existing condition. See details below
  - ☐ High potential illness / injury related absence. See details below
  - ☐ High probability of being unable to undertake the role effectively / work up to standard
  - ☐ Weight >120kg (for Mobile Plant Operator (MPO) or Mobile Plant Maintenance fitter roles
  - ☐ Other. See details below
- ☐ **Further INFORMATION required to establish fitness for proposed role**
  - ☐ Required from treating medical practitioners to follow up on incidental new positive findings, suboptimal control or clarify control of existing condition (copy of letter attached)
  - ☐ Required from proposed employer (please call ___________________________________).
  - ☐ Suggest practical assessment (employer please organise).
  - ☐ Suggest formal fitness for work/occupational physician assessment

Details:

Date:	Doctors Stamp
Signature:	

[1] ** Drug screen test results may not yet be available. Positive drug screens are frequently an administrative issue unless related to safety critical work and should be managed according to the organisation's drug and alcohol policy. We highly recommend confirmatory GCMS for positive drug results. Confirmed drug screens will preclude the subject from safety critical work.

[2] ** (Un) Acceptable risk is based upon the likelihood and magnitude of any possible adverse consequence in the job role (inherent requirements including work in remote locations, shift work etc.) as per the Disability Discrimination Act

PRE-PLACEMENT MEDICAL EXAMINATION			
1	Has done proposed job safely and effectively with same or different employer **(and in a similar environment)** within past 3 months	No ☐	Yes ☐
2	Is >= 45yo, with above average for age **risk of adverse cardiovascular event** (past history of CVD/ IHD AND/OR 2 of the following [please circle]: diabetes, systolic BP >140, smoker, known high cholesterol, BM>=40, family history). May require further tests/ reports.	No ☐	Yes ☐
3	Past history of significant workers' compensation claim[3]	No ☐	Yes ☐
4	Past (lasting more than **6 weeks**) or current history, or examination evidence (including functional test result) of a **SHOULDER, ELBOW or WRIST** DISORDER?	No ☐	Yes ☐
5	History of neck and back complaints lasting more than **6 weeks** AND/OR recurrent low-grade **NECK** and **LOW BACK** complaints AND/OR intolerance to vibration, jarring, jolting forces, AND/OR intolerance to prolonged sitting and bending?	No ☐	Yes ☐
6	Past (lasting more than **6 weeks**) or current history, or examination evidence (incl. functional test result) of a **KNEE** or **ANKLE** injury?	No ☐	Yes ☐
7	Past (lasting more than **6 weeks**) or current history, or examination evidence (incl. functional test result) of any **OTHER MUSCULOSKELETAL** injury?	No ☐	Yes ☐
8	Current and/or recent regular use of **Schedule 4 (& above) analgesic medication, benzodiazepines, and/or antipsychotic medication**. (Consider discussing with proposed employer).	No ☐	Yes ☐
9	Requires other **medications** for control of medical condition(s)?	No ☐	Yes ☐
10	**Conditions** that MAY affect the worker's ability to meet the inherent requirements of the job; including attendance, productivity, risk of injury and safety standards? (Consider discussing with proposed employer).	No ☐	Yes ☐
11	Weight I **BMI** (**circle** if weight >= 120kg or BMI >=40)	No ☐	Yes ☐
Details:			

OTHER TESTS Results (N) = Normal					
☐	Audiogram ☐ *Tick if meets **commercial driver** criteria* ☐ *Tick if full audiology assessment required*		☐	Functional & Strength Test	
			☐	Aerobic Capacity	
☐	Spirometry		☐	Fatigue & Alcohol Management	
☐	Urine Drug Screen		☐	Low Risk ESS 0-10	☐ Moderate Risk ESS 11-15; Audit >8 ☐ High Risk (ESS 16+; Audit > 8) Discussion with employer
☐	Kessler (K10) Psych Q		☐	Other	

[3] Only includes work injury requiring more than 6 months off work and/or did not return to the same job or same employer within 6 months and/or permanent disability or impairment assigned

NORTHERN STAR
RESOURCES LIMITED

PRE-EMPLOYMENT MEDICAL FORM

PRE-PLACEMENT MEDICAL ASSESSMENT[4]

PERSONAL DETAILS

Surname		Other Names	
Date of Birth		Best Contact No.	
Email			
Address			
Position/Facility		Company	

TREATING DOCTORS e.g. Your General Practitioner (**MUST BE FILLED**)

Name:	Address/Suburb:

CURRENT JOB (please note the doctor does not have access to your CV)

Are you currently working?	☐ No (proceed to NEXT section 'OTHER JOB HISTORY'	☐ Yes (complete details below)
Current Employer	**Job Title**	**Start Date (Month/Year)**

OTHER JOB HISTORY (starting from most recent other than current job detailed above)

Company/Industry	**Job Title**	**Start-Finish (Approx. Month/Year)**

REGULAR RECREATIONAL ACTIVITIES (type & frequency e.g. Cricket twice/week)

LIFESTYLE HABITS

Do you smoke?	Yes ☐ / No ☐	If yes, average amount per day	
Do you drink alcohol?	Yes ☐ / No ☐	If yes, average number of drinks standard drinks per week	

FUNCTIONAL DIFFICULTIES

Any trouble with the below tasks?	Yes	No
Sitting in a vehicle travelling over rough roads or terrain for long periods?		
Work in confined spaces or at heights		
Climb ladders		
Walk on rough ground		
Crouch/kneel and/or negotiating stairs		
Lifting 20kg or heavy luggage		
Use hand tools and carry tool bags		
Work with both hands above head		

Any trouble with the below tasks?	Yes	No
Wearing personal protective equipment e.g. safety boots, safety glasses, hearing protection, respiratory protection		
Travel in a small plane		
Shift work – nights/days, 12hour shifts		
Hot conditions – e.g. heat stress		
Repetitive work involving hands and arms		
Radio communication/hearing		
Comments:		

Applicant to fill this page

[4] Pre-Placement Medical Assessment screens an apparently healthy work population to identify risk factors which may affect an individual's ability to undertake the inherent requirements of the job applied for safely and effectively. As this service is a general screening assessment, in some complex situations a more detailed fitness for work assessment by a specialist occupational physician may be recommended as per requirement of Disability Discrimination Act.

NORTHERN STAR
RESOURCES LIMITED

PRE-EMPLOYMENT MEDICAL FORM

MEDICAL HISTORY Have you now, or have you previously had, any of the following conditions?
(✓Tick YES or NO in column. If YES, then circle relevant condition e.g. high blood pressure, asthma etc.)

		Yes	No	Doctor's Comment
1	High blood pressure, chest pain, palpitations, **heart disease,** or other heart condition?			
2	Varicose veins or poor circulation?			
3	Asthma, bronchitis, emphysema, persistent cough or **shortness of breath**?			
4	Hernias, hepatitis, peptic ulcer, haemorrhoids, recurrent diarrhoea or other **bowel problem**?			
5	**Kidney**, or other urinary tract problem?			
6	**Diabetes**, thyroid or other endocrine problem? *			
7	Epilepsy, fits, faints, funny turns, **loss of consciousness**?			
8	**Sleep disorder**?			
9	Weakness/numbness in arms or legs			
10	**Hearing loss**, ringing in ears, disturbance of balance, recurrent **ear infections**?			
11	Any **eye disorder** including **colour blindness** and the need to wear glasses or contact lenses?			
12	Skin cancer, dermatitis, eczema or **rash**?			
13	**Allergies** or reactions to dust, chemicals, medications, bee stings etc.?			
14	Any recurring or chronic **infectious disease** e.g. HIV, TB			
15	**Psychiatric condition** such as anxiety, depression, panic disorder, post-traumatic stress, adult ADHD, schizophrenia etc.?			
16	**Arthritis**, **gout**, stiff joints, joint injuries?			
17	**Neck pain**/whiplash?			
18	**Back pain** or sciatica?			
19	**Injuries** to the shoulder, elbow, wrist or hand?			
20	**Injuries** to hip, knee, ankle or foot?			
21	**Fractures** or broken bones?			
22	"**Repetitive strain injury**" such as tendonitis, tennis elbow, carpal tunnel syndrome or other overuse condition?			
23	Any other significant **operation**, injury or condition?			
24	Did you have more than 2 days sick leave over the past 12 months?			
25	Do you have a condition, disability or impairment that your supervisor should be aware of for **your safety and the safety of others** or other reasons?			

CURRENT REGULAR TREATMENTS INCLUDING MEDICATION (please list)

1.	3.
2.	4.

ONCE OFF MEDICATION

HAVE YOU TAKEN ANY COUGH/ COLD MEDICATION, SLEEPING TABLETS, PAIN KILLERS OVER THE PAST 10 DAYS?

☐ NO ☐ YES (PLEASE LIST) **1.** ____________________ **2.** ____________________

WHY DID YOU TAKE THE MEDICATION: ____

Flag for Doctors only: * *If history of diabetes, require information regarding hypoglycaemic episodes and HBA1C result within the past 3 months.*

Doctor's Comment:

Additional information sheet used? ☐ Yes ☐ No

Applicant to fill this page

KESSLER PSYCHOLOGICAL DISTRESS SCALE (K10)

	Please tick the answer that is correct for you:	All the time (score 5)	Most of the time (score 4)	Some of the time (score 3)	A little of the time (score 2)	None of the time (score 1)
1	In the past 4 weeks, about how often did you feel tired out for no good reason?					
2	In the past 4 weeks, about how often did you feel nervous?					
3	In the past 4 weeks, about how often did you feel so nervous that nothing could calm you down?					
4	In the past 4 weeks, about how often did you feel hopeless?					
5	In the past 4 weeks, about how often did you feel restless or fidgety?					
6	In the past 4 weeks, about how often did you feel so restless you could not sit still?					
7	In the past 4 weeks, about how often did you feel depressed?					
8	In the past 4 weeks, about how often did you feel that everything is an effort?					
9	In the past 4 weeks, about how often did you feel so sad that nothing could cheer you up?					
10	In the past 4 weeks, about how often did you feel worthless?					
	Total					

NOTES:

FATIGUE & ALCOHOL MANAGEMENT

Please answer the following by ticking the correct box. If you are not sure, leave the question blank and ask the doctor what it means. The doctor will ask you additional questions during the exam.	**No**	**Yes**
1. Are you currently being treated by a doctor for any illness or injury?	☐	☐
2. Are you receiving any medical treatment or taking any medication (either prescribed or otherwise)?	☐	☐
3. Please tick the following:		
3.1. Have you ever had, or been told by a doctor that you had a sleep disorder, sleep apnoea, or narcolepsy?	☐	☐
3.2. Has anyone noticed that your breathing stops or is disrupted by episodes of choking during your sleep?	☐	☐
3.3. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? (Epworth Sleepiness Scale) *This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.*		

Applicant to fill this page

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Use the following scale to choose the most appropriate number for each situation:	Situation	Chance of Dozing (0-3)
0 = would never doze off	Sitting and reading	
1 = slight chance of dozing	Watching TV	
2 = moderate chance of dozing	Sitting, inactive in a public place (e.g. theatre or meeting	
3 = high chance of dozing	As a passenger in a car for an hour without a break	
It is important that you put a number (0-3) in each of the 8 boxes	Lying down to rest in the afternoon when circumstances permit	
	Sitting and talking to someone	
	Sitting quietly after a lunch without alcohol	
	In a car, while stopped for a few minutes in the traffic	

	No	Yes
4. Do you use illicit drugs?	☐	☐
5. Do you use any drugs or medications not prescribed for you by a doctor?	☐	☐
6. Have you been in a vehicle crash since your last licence examination? If yes, please give details:	☐	☐

Please tick the answer that is correct for you (Audit Questionnaire):

7.1 How often do you have a drink containing alcohol?
☐ Never ☐ Monthly ☐ 2 to 4 times a month ☐ 2 to 3 times a week ☐ 4 or more times a week

7.2 How many drinks containing alcohol do you have on a typical day when you are drinking?
☐ 1 or 2 ☐ 3 to 5 ☐ 5 to 6 ☐ 7 to 9 ☐ 10 or more

7.3 How often do you have six or more drinks on one occasion?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7.4 How often during the last year have you found that you were not able to stop drinking once you had started?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7.5 How often during the last year have you failed to do what was normally expected from you because of drinking?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7.6 How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7.7 How often during the last year have you had a feeling of guilt or remorse after drinking?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7.8 How often during the last year have you been unable to remember what happened the night before because you had been drinking?
☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7.9 Have you or someone else been injured as a result of your drinking?
☐ No ☐ Yes, but not in the last year ☐ Yes, during the last year

7.10 Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?
☐ No ☐ Yes, but not in the last year ☐ Yes, during the last year

Applicant to fill this page

PRE-EMPLOYMENT MEDICAL FORM

CLAIMS HISTORY

Are you currently, or have at any time, been in receipt of Worker's Compensation, Personal Injury Insurance payments (including those resulting from motor vehicle accident), disability pension or other benefits as a result of sickness, incapacity or disability? ☐ Yes ☐No

If yes, please give details.

Approx. Date/ Year of Occurrence:		
Employer:	Type of work:	
Mechanism of injury (how did you do it?):		
Type of Injury:		
Treatment required:		
Period of Time off work:	Period of restricted duties:	
Returned to full duties with same employer? ☐ Yes ☐ No		
Details if No:		
Current symptoms and functional limitations:		
Current Treatment:		

Approx. Date/ Year of Occurrence:		
Employer:	Type of work:	
Mechanism of injury (how did you do it?):		
Type of Injury:		
Treatment required:		
Period of Time off work:	Period of restricted duties:	
Returned to full duties with same employer? ☐ Yes ☐ No		
Details if No:		
Current symptoms and functional limitations:		
Current Treatment:		

Any other claims not listed above? ☐ **Yes** ☐ **No**

DECLARATION BY APPLICANT

- I declare that I have read and understand the information sheet **"Preplacement Medical Examinations"**. I consent to the collection, use and disclosure of my medical information as per this information sheet. I consent to clarification of medical information with my treating medical practitioner if necessary. I acknowledge results will be released to an employer, prospective employer or authorised company representative.
- I declare that I have answered all questions (including questions on any signed supplementary forms) honestly, correctly and completely. I have not knowingly withheld any relevant information.
- I declare that I understand that incorrect or misleading statements or omission may:
  - Render me liable for termination of appointment
  - Render me liable to disciplinary action
  - Negate any future claim for compensable injury/ illness

"Where it is proved that the worker has, at the time of seeking or entering employment in respect of which he claims compensation for an injury, wilfully and falsely represented himself as not having previously suffered from the injury, the arbitrator may in the arbitrators discretion, refuse to award compensation that would otherwise be payable" Workers Compensation and Injury Management Act (WA) 1981, Section 79"

Signature of Applicant:

Name of Applicant:

Applicant to fill this page

PRE-PLACEMENT MEDICAL EXAMINATIONS

Purpose

The sole purpose of this medical assessment is to determine the person's ability (with or without modifications) to undertake the inherent requirements of the job;

1. Effectively
2. Without significant safety risk to their physical and mental wellbeing and that of their workmates.

The pre-placement medical examination is not the same as visiting a general practitioner on a routine basis for overall health checks. It does not address general health risks, disease or preventative health issues in detail; for example cholesterol checks or cancer screening.

An employer may refer to any relevant information collected in the event of any accident, injury, sickness or claim for workers' compensation relevant to the person.

Rights and Obligations

The presence of a disability should not be a bar to employment if the person is able to safely and effectively perform the duties without the provision of services or facilities which would impose unjustifiable hardship on the prospective employer.

We recommend to employers that this assessment is only one step of the selection process. If the person is not already employed, the employer is responsible for any final selection after considering all aspects of the person's application.

Should the person fail to disclose any relevant information relating their ability and safety to remain at work and carry out the duties for which they were employed;

1. Their employment may be terminated.
2. Any future claim for workers' compensation may be denied.

Collection, Use, Storage and Access of Personal Medical Information

The information collected for the purpose of this assessment includes a full work and medical history as well as relevant physical examination. Clarification of relevant information may be sought from the treating medical practitioner.

The only information used will be that which is regarded as necessary for the purpose of the medical assessment. The relevant information will be sent directly to the referring person or the designated person within the potential employing organisation.

We will endeavour to ensure that all information that we collect, use and disclose for the purpose of the assessment is accurate and complete. We will endeavour to take reasonable steps to protect all personal information from loss, misuse, unauthorised disclosure or destruction.

Pursuant to the National Privacy regime, patients assessed are entitled to contact us and ask for access to the personal information which we collect about them. As a general rule, we are obliged to release to you, on request, the information that is collected during the course of your assessment.

However, it is considered that the party who commissioned and paid for your assessment acquires a propriety interest in the results reached (or recommendations made). Therefore, any decision to release the results (or recommendations made), will depend on the attitude of the commissioning party to the release of that information.

Please otherwise note that unauthorized use of the information released to you, including its provision by you to a third party is prohibited.

– I declare that I have read and understand the aforementioned information. I consent to the collection, use and disclosure of my medical information as per this information sheet. I consent to clarification of medical information with my treating medical practitioner if necessary.

Name of Applicant:____

Signature of Applicant:____________________________________ **Date:**__________________

Applicant to fill this page

NORTHERN STAR RESOURCES LIMITED

PRE-EMPLOYMENT MEDICAL FORM

TO BE COMPLETED BY THE MEDICAL PRACTITIONER

VITAL MEASUREMENTS (BP > 140/90 REQUIRES FOLLOW UP LETTER TO GP)						
Ht cm	**Wt** kg	**BMI**	BP 1.	2.	3.	Pulse: ☐Reg / ☐Irr

URINALYSIS		
☐Normal	☐Abnormal**	Blood Glucose Protein Ketones Other

VISION					
Acuity		UNCORRECTED	CORRECTED	***Colour Vision** Normal YES ☐	NO ☐ Plates Incorrect ____
				*Colour vision impairment may require **practical testing**.	
Near	L	N	N	**Peripheral Vision** Right > 45^0 YES ☐ NO☐	
	R	N	N	Left > 45^0 YES ☐ NO☐	
	Both	N	N	**SIGHT ACCEPTABLE? YES ☐ NO☐**	
Far	L	6/	6/	**Comment:**	
	R	6/	6/		
	Both	6/	6/		

FUNCTIONAL ASSESSMENTS			
Sits comfortably ………………	YES ☐ NO ☐	Able to squat……………………………………………	YES ☐ NO ☐
Gait normal …………………….	YES ☐ NO ☐	Able to hop …………………………………………….	YES ☐ NO ☐
Walk on heels …………………	YES ☐ NO ☐	Touch palms above head ………………………….	YES ☐ NO ☐
Tiptoes …………………	YES ☐ NO ☐	**Full power to resisted extension of wrist/ fingers ….**	YES ☐ NO ☐
Quadriceps bulk/tone ……….	SYM ☐ ASYM ☐	Hand grip symmetric ……………………………….	YES ☐ NO ☐

MEDICAL EXAMINATION			
CARDIOVASCULAR		**ABDOMEN**	
Blood Pressure normal	YES ☐ NO ☐**	Abdomen normal	YES ☐ NO ☐
Pulse normal	YES ☐ NO ☐	Hernia Orifices normal	YES ☐ NO ☐
Auscultation normal	YES ☐ NO ☐	**NERVOUS SYSTEM**	
Veins Normal	YES ☐ NO ☐	Co-ordination normal	YES ☐ NO ☐
Cardiovascular System normal	YES ☐ NO ☐	Balance normal	YES ☐ NO ☐
RESPIRATORY		Reflexes normal	YES ☐ NO ☐
Symmetrical Chest Expansion	YES ☐ NO ☐	Rhomberg Test normal	YES ☐ NO ☐
Auscultation normal	YES ☐ NO ☐	**MUSCULO SKELETAL**	
Respiratory System normal	YES ☐ NO ☐	Cervical Spine normal	YES ☐ NO ☐
ENT		Lumbo-Thoracic spine	YES ☐ NO ☐
Whisper Test normal	YES ☐ NO ☐	Hands normal	YES ☐ NO ☐
Throat normal	YES ☐ NO ☐	Wrists normal	YES ☐ NO ☐
Ears normal	YES ☐ NO ☐	Elbows normal	YES ☐ NO ☐
Teeth and gums	YES ☐ NO ☐	Shoulders normal	YES ☐ NO ☐
SKIN (General and Hands)		Hips normal	YES ☐ NO ☐
Normal	YES ☐ NO ☐	Knees normal	YES ☐ NO ☐
		Ankles normal	YES ☐ NO ☐
		Straight leg raise	Right ^{0} Left ^{0}

Flag for Doctors only: ** If BP > 140/90, abnormal urinalysis requires follow-up letter to GP
Doctor's Comment:

NSR STRENGTH & FUNCTION ASSESSMENT

STRENGTH & FUNCTION ASSESSMENT	Date of Assessment:

INFORMED CONSENT & DISCLAIMER

This screening tool consists of a series of common exercises and lifting scenarios undertaken in a controlled setting to gives some indication of the subject's general strength, function and overall level of conditioning. This assessment is voluntary and can be stopped at any time by the subject or the assessor. The subject must disclose to the assessor any medical condition or injury which is likely to affect their ability to undertake the exercises safely and effectively. The subject must advise the assessor IMMEDIATELY if pain or difficulty is experienced at any time during the assessment. While the exercises are not onerous to most of the general population, are undertaken in a controlled setting and procedures are in place to minimise the risk of injury, exercise at any time does carry a small risk of injury. This assessment forms only one part of the pre-placement process and alone DOES NOT determine the subject's fitness to undertake the inherent requirements of the job placement. By signing below, you give informed consent for this assessment to proceed and agree not hold OccuMED responsible for any injury that may be sustained during this assessment.

Name:	Signature:

SUMMARY OF AEROBIC FITNESS ASSESSMENT (CHESTER STEP TEST)

Aerobic Capacity (mlsO$_2$/kg/min)

Aerobic Capacity Rating ☐**Low** ☐**Below Average** ☐**Average** ☐**High** ☐**Very High Fitness**

Comment

**If applicable, commence Musculoskeletal Assessment when HR has returned to <25bpm above resting HR.*

SUMMARY OF MUSCULOSKELETAL STRENGTH AND FUNCTIONAL ASSESSMENT

Region	**Score**		Poor	Fair	Good	Very Good
Lifting		20	☐	☐	☐	☐
Spine and Trunk		20	☐	☐	☐	☐
Upper Limb		20	☐	☐	☐	☐
Lower Limb		20	☐	☐	☐	☐
Completion Time/ Fatigue		20	>25min/ Marked (5pts)	23-25min/ Mod (10pts)	20-22min/ Mild (15pts)	<20min/ Nil (20pts)
Overall		**100**				

Comment:

Please tick:

☐ **OccuMED Subiaco**
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SUBIACO WA 6008
Tel: (08) 9381 8388
Fax: (08) 9381 7833

☐ **OccuMED Redcliffe**
331 Great Eastern Hwy
REDLIFFE WA 6104
Tel: (08) 9277 6028
Fax: (08) 9381 7833

☐ **OccuMED Murdoch**
Suite 44-45,
Lvl 2, SJOG Wexford Centre
3 Barry Marshall Parade
MURDOCH WA 6150
Tel: (08) 9478 1075
Fax: (08) 9381 7833

☐ **Other**

____
____
____
____
____

____
Signature of Assessor:

____
Name & Credentials of Assessor

PRE-EMPLOYMENT MEDICAL FORM

Office Use Only

PRE-TEST RISK ASSESSMENT

YES	NO	HISTORY OF
☐	☐	***Heart disease, chest pain with exertion or at rest?**
☐	☐	Family history of heart disease
☐	☐	High blood pressure BP._______/_______ HR _____
☐	☐	Diabetes
☐	☐	Smoker
☐	☐	> 50 years old _______
☐	☐	***BMI= > 40**

YES	NO	RECENT HISTORY OF
☐	☐	Neck, Back Pain and/or Sciatica
☐	☐	Shoulder ( ), Elbow ( ), Wrist ( ) problems
☐	☐	Hip ( ), Knee ( ), Ankle ( ) problems

Tester Comments

☐ ***Fit to proceed*** ☐ ***Proceed with care*** ☐ ***Unfit to proceed***

**Absolute contraindication*

If YES to any of the above, requires medical approval to proceed with strength and fitness testing. Doctors Initials ________

LIFTING TECHNIQUE, STRENGTH & FUNCTION

***Start Time: __________**

Floor ↔ Waist: Technique

Select suitable weight 16kg, 12kg or 8kg.

- 5 Correct first lift
- 2 Correct second lift
- 0 Incorrect first and second lifts

Waist ↔ Shoulder: Technique

Select suitable weight 16kg, 12kg or 8kg.

- 5 Correct first lift
- 3 Correct second lift
- 0 Incorrect first and second lifts

Floor ↔ Waist: Function (x10)

Ensure lifts are performed safely and with no pain. Comfortable smooth technique without jerky motions.

- 5 Able to comfortably lift 16kg 10 times
- 3 Able to comfortably lift 12kg 10 times
- 0 Able to comfortably lift 8kg 10 times

Waist ↔ Shoulder: Function (x10)

Ensure lifts are performed safely and with no pain. Comfortable smooth technique without jerky motions

- 5 Able to comfortably lift 16kg 10 times
- 3 Able to comfortably lift 12kg 10 times
- 0 Able to comfortably lift 8kg 10 times

Score

Floor to Waist: Technique		5
Floor to Waist: Function (x 10)		5
Waist to Shoulder: Technique		5
Waist to Shoulder: Function (x 10)		5
Total		**20**

Comments: ☐ Education Provided ☐ Further Training Required

☐ **0-10 Poor** ☐ **11-15 Fair** ☐ **16-19 Good** ☐ **20 Very Good**

SPINE/ TRUNK STRENGTH & FUNCTION

Abdominal Strength (1 min)

Supine, no feet support, 90◦knee flexion, perform repeated half sit-up in 1 min. Knuckles over the top of the knee.

- 5 Able to perform > 30, ½ sit-ups
- 3 Able to perform 15-30, ½ sit-ups
- 1 Unable to do perform 15, ½ sit-ups

Core Strength & Stability (Hover)

Start in the plank position with forearms and toes on the floor.
Keep body in a straight line from ears to toes with no sagging or bending. Head is relaxed, looking at the floor.

- 5 Able to sustain position for 60 seconds
- 3 Able to sustain position for 30-59 seconds
- 0 Unable to sustain position for 30 seconds

Thoracic Strength

Prone, hands at base of low back. Lift chest and shoulders at least 10cm off floor.

- 5 Able to sustain a strong contraction for 60 seconds
- 3 Able to sustain a strong contraction for 40-59 seconds
- 0 Unable to sustain a strong contraction for 40 seconds

Lumbar Strength

Prone, chest and abdomen flat on bed. Bilateral leg extension, knees extended.

- 5 Perform >10 comfortably
- 2 Perform 5-10 comfortably
- 0 Unable to correctly perform 5

Score

Abdominal Strength		5
Thoracic Strength		5
Core Strength & Stability		5
Lumbar Strength		5
Total		**20**

Comments:

☐ **0-10 Poor** ☐ **11-15 Fair** ☐ **16-19 Good** ☐ **20 Very Good**

UPPER LIMB STRENGTH & FUNCTION

Supraspinatus Strength

'Empty-Can' - GH joint full IR, abduct shoulder 90 degrees.
Men:2 kg, Women:1 kg

5	Able to comfortably perform >15 times
3	Able to comfortably perform 10-15 times
0	Unable to comfortably perform 10 times

Shoulder Press (4kg Dumbbells)

Position dumbbells to each side of the shoulders. Press dumbbells upwards until arms are extended overhead. Lower to sides of shoulders.

5	Able to comfortably lift >10 times
3	Able to comfortably lift 5-10 times
0	Unable to comfortably lift 5 times

REST / DRINK

Push-Ups (Chest/Shoulder/Triceps)

Prone. Men (full push-ups) Women (half push-ups – knees on floor)

5	15 without pain
3	8-14 without pain
1	2-7 without pain

Hand Grip Strength/ Dynamometer

Best of three.

5	≥48kg (males), ≥ 26kg (females) - bilaterally
3	40-47kg (males), 21-25kg (female) – unilateral or bilateral
0	<40kg (males), <20 (females) or asymmetric grip strength >50%

Score		
Supraspinatus Strength		5
Shoulder Press		5
Push-Ups		5
Hand Grip Strength		5
Total		**20**

Comments:

RHGrip	LHGrip

☐ **0-10 Poor** ☐ **11-15 Fair** ☐ **16-19 Good** ☐ **20 Very Good**

LOWER LIMB STRENGTH & FUNCTION

Wall Squat/Slides

20 comfortably without any pain
15-19 comfortably without pain
Less than 15

Steps

Steps up and down 25cm high platform. Perform 5 steps leading with the right, followed by the left leg.

5	Able to perform 10 steps without pain
3	Able to complete 5-9 without pain
0	Unable to complete 5 without pain

Hopping (2 metres)

Hop in a line - Note pain and proprioception, at least 2cm off the ground.

5	Able to hop without difficulty (both sides)
3	Able to hop but appears slightly unstable L / R
0	Unable to hop (pain or severe instability) L / R

Stork Balance Test

Single leg stance, position non supporting foot against the inside knee of supporting leg, place hands on hips

5	>25 seconds - bilateral
2	10-24 seconds – unilateral or bilateral
0	<10 seconds - unilateral

Score		
Wall Squat/Slides		5
Steps		5
Hopping		5
Stork Balance Test		5
Total		**20**

Comments:

☐ **0-10 Poor** ☐ **11-15 Fair** ☐ **16-19 Good** ☐ **20 Very Good**

*Completion Time: ________

Chester Step Test data collection and results sheet

Name ________________________ **Age** _______ **MaxHR** _______ **b/min** **80%MaxHR** _______ **b/min**

MaxHR = 220 - Age

80%MaxHR = MaxHR x 0.80

Tick when checked

Readiness to exercise check ________________

Contra-indications to exercise ________________

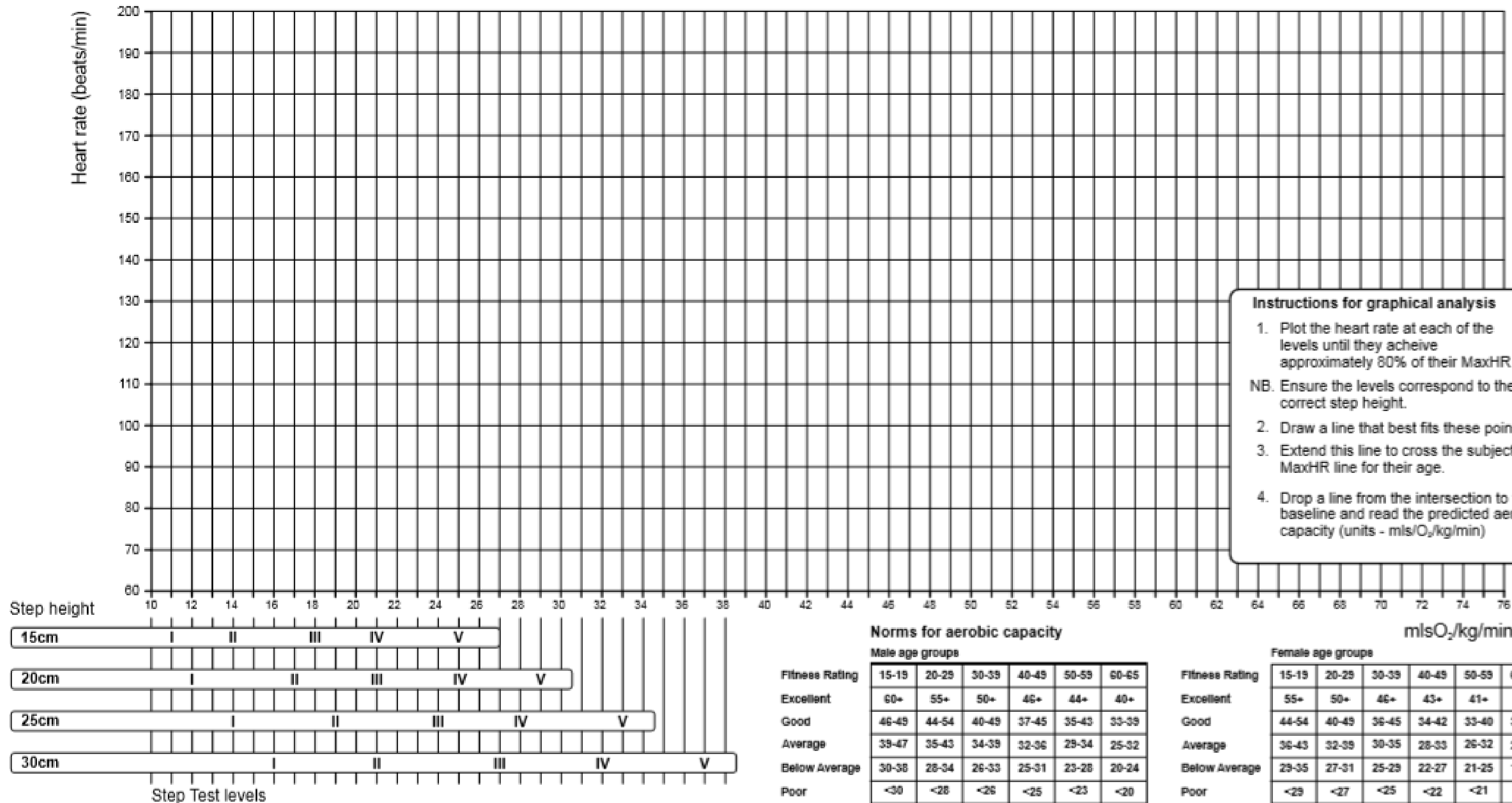
Lifestyle activity level check ________________

Step height for test _______ cm

Tester's Initials ________________

Stop level	I	II	III	IV	V
Heart rate recorded at each level					
Exertion level from RPE scale					

Date of test:	
Aerobic capacity: (mlsO$_2$/kg/min)	
Fitness rating:	
Remarks:	



Instructions for graphical analysis

1. Plot the heart rate at each of the levels until they acheive approximately 80% of their MaxHR.

NB. Ensure the levels correspond to the correct step height.

2. Draw a line that best fits these points.
3. Extend this line to cross the subject's MaxHR line for their age.
4. Drop a line from the intersection to the baseline and read the predicted aerobic capacity (units - mls/O$_2$/kg/min)

Norms for aerobic capacity

Male age groups

Fitness Rating	15-19	20-29	30-39	40-49	50-59	60-65
Excellent	60+	55+	50+	46+	44+	40+
Good	46-49	44-54	40-49	37-45	35-43	33-39
Average	39-47	35-43	34-39	32-36	29-34	25-32
Below Average	30-38	28-34	26-33	25-31	23-28	20-24
Poor	<30	<28	<26	<25	<23	<20

Female age groups

Fitness Rating	15-19	20-29	30-39	40-49	50-59	60-65
Excellent	55+	50+	46+	43+	41+	39+
Good	44-54	40-49	36-45	34-42	33-40	31-38
Average	36-43	32-39	30-35	28-33	26-32	24-30
Below Average	29-35	27-31	25-29	22-27	21-25	19-23
Poor	<29	<27	<25	<22	<21	<19

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