

# Pre-Placement Health Assessment Form

To be completed by the applicant. Please return form and proof of immunity toPathWest.PEHA@health.wa.gov.au.

Placement cannot commence until this form has been completed and assessed by the appropriate department.

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname: |  | | | | Name: |  | | | Sex: |  |
| Date of birth: |  | | | Contact phone: |  | | | | | |
| Email address: |  | | | | | | | | | |
| Placement role: |  | | | | | | | | | |
| Placement site: |  | QEIIN | | | | | | | | |
|  | FSH | | | | | | | | |
|  | RPH | | | | | | | | |
|  | RSS | | | | | | | | |
| Placement department: | | | |  | | | | | | |
| Placement supervisor/coordinator: | | | |  | | | | | | |
| Date of placement | | | From: |  | | | To: |  | | |
| Level of patient contact: | | |  | Direct contact with blood or body substances | | | | | | |
|  | Direct patient contact | | | | | | |
|  | No patient contact (administrative role) | | | | | | |

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| **Part A: Fitness for work** | | | | | | | | | | | |
| Are you currently being treated by a doctor or health professional for any illness or injury? | | | | | | | | | | Yes  No | |
| Details: |  |  |  |  | |  |  |  |  |
| Do you have a medical condition which may be aggravated or could reoccur due to the type of work you will be undertaking while on placement? | | | | | | | | | | Yes  No | |
| Details: |  |  |  |  | |  |  |  |  |
| Are there any reasons that you may not be able to physically, emotionally, or mentally perform the duties assigned to you while on placement? | | | | | | | | | | Yes  No | |
| Details: |  |  |  |  | |  |  |  |  |
| Do you have a current workers’ compensation claim or have you ever made a claim for workers’ compensation, motor vehicle injury, disability, or invalidity?  Details: | | | | | | | | | | Yes  No | |
| Do you require any modification/adjustments in the workplace to allow you to carry out your role? For example, if colour vision, hearing, or mobility impaired. | | | | | | | | | | Yes  No | |
| Details: |  |  |  |  | |  |  |  |  |
| To ensure your safety whilst on site, you must provide proof of vaccination and/or supply serological evidence of immunity as per below, prior to commencing the placement. Your General Practitioner, Staff Health or University can assist with this. | | | | | | | | | | | | |
| **Part B: Infection prevention – Health and Immunisation requirements** | | | | | | | | | | | | |
| **Immunisation History** | | | | | **Acceptable evidence to demonstrate protection** | | | | | | **Proof attached?** | |
| Measles, Mumps, Rubella (MMR) | | | | | Documented evidence of two doses of MMR vaccine at least 1 month apart, or positive IgG for MMR | | | | | |  | |
| Varicella (Chickenpox) | | | | | Documented evidence of positive varicella IgG or two varicella vaccinations at least one month apart | | | | | |  | |
| Hepatitis B (Applicable for direct patient contact and contact with blood or body substances) | | | | | Documented evidence of a completed, age-appropriate course of hepatitis B including evidence of post vaccination hepatitis B surface antibody ≥10 mIU/mL or presence of anti- HBc | | | | | |  | |
| Pertussis (Whooping Cough) / Diphtheria / Tetanus | | | | | One documented dose of adult dTpa vaccine within the last 10 years | | | | | |  | |
| Influenza Vaccination (Recommended) | | | | | Current winter season influenza vaccination | | | | | |  | |
| COVID-19 Vaccination Status (Recommended) | | | | | Documented evidence of COVID-19 vaccination | | | | | |  | |

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| **Tuberculosis screening** (Only applicable for placements with direct patient contact) | | **Proof attached?** |
| Have you had a BCG vaccination? | Yes  No |  |
| Baseline screening (Mantoux or QuantiFERON test): | Date: |  |

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| **MRSA Screening** (Only applicable for placements with direct patient contact) | | |
| Have you been working or been a patient in a hospital or nursing home **outside** Western Australia in the last 12 months? (If yes, please provide a copy of the nose and throat screening. MRSA screening swabs can be collected outside of WA, as long as the applicant has not worked since collection of the screening swabs) | Yes | No |

**Applicant Declaration:**

I declare that the information I have provided is accurate to the best of my knowledge. I have not withheld any relevant information. I declare, I am fit for the inherent requirements of placement and understand I must immediately report any fitness issues to my placement supervisor

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

**Instructions:** Infection Prevention and Management, and Work Health and Safety/WHS review is required for all new starters. Please forward this form to PathWest.PEHA@health.wa.gov.au.

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| **Infection Prevention and Management Use Only** | | | |
|  | Review of the results meets infection control requirements. Approved to commence placement. Please return to sender | | |
|  | Review of the results does not meet infection control requirements. Placement unable to commence. Please return to sender | | |
|  | Incomplete information. Placement unable to commence. Please return to sender | | |
| **Name**: | | **Signature**: | **Date:** |
| **Work Health and Safety Use Only** | | | |
|  | Complete. No Issues. Approved to commence placement. Please return to sender | | |
|  | Complete. Evidence of fitness from treating medical practitioner required prior to placement commencing. Please return to sender | | |
|  | Incomplete information. Placement unable to commence. Please return to sender | | |
| **Name**: | | **Signature**: | **Date** |