Medical Questionnaire and Consent Form

CANDIDATE DETAILS

First name	Surname	DOB

Contact telephone number	Email address

Home address	GP Surgery

Employer's name	Sponsor's name	Job title

National insurance number	Sentinel number

Do you currently hold a Sentinel card? NO ☐ YES ☐ → **If YES does this card show any endoresement eg red triangle?** NO ☐ YES ☐ Endorsement type e.g. symbol

EMPLOYMENT HISTORY

QUESTION	CIRCLE	IF YES, PLEASE RECORD FURTHER DETAILS (provide as much information as possible incl dates)	OFFICE USE ONLY
Have you been absent from work due to sickness during the last two years?	**Y / N**		
Have you ever left, or been denied a job for health reasons?	**Y / N**		
Have you ever had an illness caused by your work?	**Y / N**		

MEDICAL HISTORY

HAVE YOU EVER HAD OR SUFFERED FROM:	CIRCLE	IF YES, RECORD FURTHER DETAILS- provide as much information as possible incl dates/ current state of condition/ last GP visit & side effects - this will be used to make decisions on fitness.	OFFICE USE ONLY
Heart Disease or circulatory condition? E.g. angina, arrhythmia, heart attack, high blood pressure, stroke or aneurysm.	**Y / N**		
Respiratory Disease or Lung Condition? E.g. Asthma, COPD or breathing problems	**Y / N**		

MEDICAL HISTORY			
HAVE YOU EVER HAD OR SUFFERED FROM:	CIRCLE	IF YES, RECORD FURTHER DETAILS- provide as much information as possible incl dates/ current state of condition/ last GP visit & side effects - this will be used to make decisions on fitness.	OFFICE USE ONLY
Neurological Condition? E.g. MS, Parkinson's, Epilepsy, Migraine, Brain Injury or surgery.	**Y / N**		**GP**
Weakness, numbness, tremor, clumsiness, poor balance, fits or fainting?	**Y / N**		
Mental Health Illness? E.g. Depression, anxiety, bipolar disorder, schizophrenia, deliberate self-harm.	**Y / N**		**HADS**
Musculoskeletal Condition? E.g. Injury, arthritis, problems with bones, tendons or joints.	**Y / N**		
Sleep Disorders, trouble sleeping or Excessive Fatigue? E.g. Sleep apnoea, Chronic Fatigue etc	**Y / N**		**ESQ**
Endocrine Disorder? E.g. Diabetes, Thyroid Disease, Adrenal Disease.	**Y / N**		**GP**
Behavioural or Developmental Disorder that could affect your assessment of Risk? E.g. Asperger's or ADHD	**Y / N**		
Visual impairment needing glasses or lenses or other eye issues? E.g. short sighted, Colour Blindness.	**Y / N**		**Opt.**
Have you ever had Laser eye Surgery?	**Y / N**		**Opt.**
Difficulties with hearing or problems with the ears?	**Y / N**		
Do you wear hearing aids? **(they must not be worn for hearing test)**	**Y / N**		
Speech Impediment?	**Y / N**		**L2/L4**

MEDICAL HISTORY

HAVE YOU EVER HAD OR SUFFERED FROM:	CIRCLE	IF YES, RECORD FURTHER DETAILS- provide as much information as possible incl dates/ current state of condition/ last GP visit & side effects - this will be used to make decisions on fitness.	OFFICE USE ONLY
Bowel Disorder?	**Y / N**		
Disease of the Kidney?	**Y / N**		
Disease of the Liver?	**Y / N**		
Allergies or Hay fever?	**Y / N**		
Are you regularly taking any medication either over the counter or prescribed? Include name, dose, strength and frequency taken.	**Y / N**		**MED** transfer details to Assess. record
If YES- Do you experience side effects from any of the above medications? eg dizziness/drowsiness	**Y / N**		
Are you currently receiving medical treatment?	**Y / N**		
Have you ever had tests or treatment at a hospital or clinic (including operations)? If yes, record the date.	**Y / N**		
Are there any aspects of your health which you think are relevant to your proposed work?	**Y / N**		

LIFESTYLE

Do you take exercise at least three times a week, lasting 20 minutes or more?	**Y / N**		
Do you smoke? If so, for how long and how much?	**Y / N**		**A**

LIFESTYLE

Are you an ex-smoker? If so, how long is it since you stopped and how much did you previously smoke?	**Y / N**	**Years:** **Months:** **Amount:**	
Do you regularly consume alcohol? If so, how many units of alcohol do you consume on average each week?	**Y / N**	*(One unit is half a pint of beer, a small glass of wine or a single shot)*	**A** if >14 units/ week

GENERAL DATA PROTECTION REGULATION

1. The service provider is Crystal Health Group Limited.
2. Crystal Health Group Limited rely on your consent as the lawful basis for processing and holding your data.
3. I verify that the information contained on this form is correct and true to the best of my knowledge.
4. All personal data provided will be used to uniquely identify you as a candidate and provide the necessary information and biological sample to perform the medical assessment.
5. My personal data will not be shared with any other third-party unless authorised in writing or ordered by my employer. To request a third-party consent form, please write to info@crystal-health.co.uk You will be required to provide answers to security questions to access this service.
6. I understand that the biological specimens and associated personal data will be stored in compliance with the service provider's Archive Policy. To request a copy of your personal data, please write to info@crystal-health.co.uk You will be required to provide answers to security questions to access this service.
7. I have the right to request erasure of my personal data. This may be subject to restrictions according to the service provider's Archive Policy and retention periods required for the type of medical performed. This is also subject to any other legitimate lawful reasons, including a court order or legal claim. More detailed information regarding your rights under the General Data Protection Act for personal data can be viewed at www.crystal-health.co.uk within the service provider's Client Privacy Policy.
8. I acknowledge and agree that the service provider's liability to me arising out of or in any way related to the provision of testing services contemplated herein shall not exceed the cost of the medical, and I agree to indemnify, defend, and hold the service provider, its officers, agents, employees, representatives and any persons or entities collecting specimens harmless from all further claims or damages.
9. I acknowledge and understand that if for any reason the biological specimen is inadequate for evaluation, The service provider or the entities collecting specimens shall not be held liable if it is unable to produce medical results due to insufficient specimen or due to lack of information. The service provider may request additional samples or further information following the assesment, which will incur additional costs.
10. I understand that all email results will be sent by secure email and password protected.
11. I understand that I have the right to withdraw consent for my participation from this medical assessment at any time. My samples and associated personal data will be destroyed, subject to restrictions. To withdraw your consent after your medical assessment has been performed, please write to info@crystal-health.co.uk You will be required to provide proof of identity (Passport/Driving Licence) and answers to security questions to access this service. Cancellation and processing fees will apply in the case of withdrawn consent.

CONSENT DECLARATION

In signing this declaration I confirm that:

1. The answers given on this document are to the best of my belief, true and complete.
2. I consent to Crystal Health Group Limited conducting the Competence Specific Medical Assessment.
3. I have read and understood the GDPR information provided above.
4. I understand that the personal and medical information provided will be retained by Crystal Health Group Limited and treated confidentially and shared with our external Occupational Physician when required.

I understand that a recommendation on fitness for employment and/or my fitness to carry out my duties will be provided to my employer and reported to the Sentinel scheme, Network Rail and / or their representatives.

Candidate signature of consent _____ Date _____