

**Skin Health Surveillance Questionnaire.**

***To be used by the designated Responsible Person (RP) for staff identified as requiring skin health surveillance***

**Failure to fully complete all sections of this form will result in the form being returned.**

 **SECTION 1: To be completed by the employee.**

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| **empLOYEE DETAILS:** |
| Surname:       | Forename:       | Gender:      Date of Birth:       |
| Permanent Address:       |
| Postcode:       | Contact Number/Mobile number:       |
| Email Address:       | **Consent to participate in health surveillance programme** |
| Job Title:       | I understand that skin health surveillance is necessary in this employment .The information contained within this form is a true and accurate record and I consent to health surveillance by my participation and by my signature on this form. I accept that my line manager will use this form to escalate to occupational health if required.**I will inform my manager or the responsible person immediately if I develop any skin problems after completing this form.**By providing my details I agree to Occupational Health contacting me for further information or an appointment. In this |
| Ward / Dept:      Directorate:      Hospital/Location:       |
| **Signature of employee:**      **Date:**       |

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| **What substances/gloves do you use or might be exposed to?** (Tick the box that relates to the products you use) |
| Soap products (please state type)  | [ ]  | Type:       |
| Alcohol gel | [ ]  | Type:       |
| Surgial scrub | [ ]  | Type:       |
| Latex gloves or other latex products | [ ]  | Type:       |
| Non-latex gloves (please state type) e.g. nitrile | [ ]  | Type:       |
| Workplace moisturiser | [ ]  | Type:       |
| Other substances e.g. detergents/disinfectants, machine oils etcPlease specify:       |
| Are there any substances at home or outside of work that affect your skin? (If yes, please give details)Details:       | Yes [ ]  No [ ]  |

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| **In the last 12 months have you had or do you currently have any of the following?** (tick all that apply) |
| Rednessdryness/swelling/crackingFlaking/scaling/blistering/itching/bleeding of **fingers, hands, wrists or forearms.** | YES [ ]  NO [ ]  | Details (Confirm if still present)       |
| Any skin issues affecting other parts of the face or arms e.g. redness, swelling, itching? (exclude facial acne, shaving rash) | YES [ ]  NO [ ]  | Details (Confirm if still present)       |
| A new diagnosis of latex allergy? | YES [ ]  NO [ ]  | Details (Confirm if still present)      |

**Section 2: To be completed by the Responsible Person**

**Failure to fully complete all sections of this form will result in the form being returned.**

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| **Visual Skin Check by the Responsible Person (please mark any areas of red, dry, damaged or broken skin on the diagrams below)** |
| **LEFT HAND**Drawings-of-left-and-right-hands-in-back-and-palmar-views-modifi-ed-from-Parsons Drawings-of-left-and-right-hands-in-back-and-palmar-views-modifi-ed-from-Parsons | **RIGHT HAND**Drawings-of-left-and-right-hands-in-back-and-palmar-views-modifi-ed-from-Parsons Drawings-of-left-and-right-hands-in-back-and-palmar-views-modifi-ed-from-Parsons |

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| **If any other areas if skin are affected e.g. face or elbows, please provide further details:**  |
| **Describe current issues**:       |

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| **Responsible Person (RP) comments (please provide any further details as required):**  |
| **Describe current issues:**       |

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| **Responsible Person Actions: Tick one option below.** |
| **NO** to all questions and **no signs** of skin damage/disease. | [ ]  | Refer to action 1. |
| **NO** to all questions **and signs** of skin damage/disease. | [ ]  | Refer to action 2. |
| **YES** to one or more questions **and no signs** of skin damage/disease. | [ ]  | Refer to action 2. |
| **YES** to one or more questions **and signs** of skin damage/disease. | [ ]  | Refer to action 2. |

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| **Action 1** | Instruct employee to report any symptoms to their line manager if they occur between now and their next skin surveillance check |
| **Action 2:** | Refer to Occupational Health for further assessment – **send completed form to occhealth@ggc.scot.nhs.uk** |

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| **Referral to Occupational Health Required?** |
| Yes [ ]  No [ ]  If yes, copy of this form to be sent to Occupational Health by Line Manager -  (This form will act as the ‘referral’ document)  |

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| **Responsible Person Name (Print):**  |
| Signature:       | Date:       |

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| **Line Manager Name (Print):**  |
| Signature:       | Date:       |
| Email address:       |
| Date copy of form sent to Occupational Health: |