

**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 etc  Please 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) | | |
| Redness  dryness/swelling/cracking  Flaking/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: | |