

6488

7

1.1 Appendix 32: EX1 Form (Initial Examination Report)

INITIAL EXAMINATION REPORT (MEDICAL – CONFIDENTIAL)

Petroleum Development Oman
MEDICAL DEPARTMENTPLEASE COMPLETE YOUR PERSONAL
DETAILS IN BLOCK CAPITALS

Place of examination <i>Adam</i>		Date <i>29/3/19</i>	Surname <i>Poshetty CIRUMAR</i>																																																																	
			Forenames																																																																	
			Address																																																																	
			Home telephone number																																																																	
			Employment No # <i>6488</i>																																																																	
If a dependant enter employee's name here:																																																																				
Surname:		Forenames:																																																																		
Birth date: <i>25-5-78</i>		Nationality: <i>India</i>		Country of birth:																																																																
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		Relationship to employee <input checked="" type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter																																																																
Number of children: <i>3</i>																																																																				
Reason for examination		Pre-Employment	Job: <i>painter</i>																																																																	
Pre-Overseas			Area:																																																																	
Name and address of family doctor		List your last 3 jobs																																																																		
		(1)																																																																		
		(2)																																																																		
Are you a Registered Disabled Person? (UK only)		<input type="checkbox"/>	Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>																																																																	
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)																																																																				
<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>21. Cancer</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>22. Heart Disease</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>23. Rheumatic fever</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>24. Abnormal heartbeat</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>25. High blood pressure</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>26. Stroke</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>27. Serious chest pain</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>28. Any blood disease</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>29. Kidney disease</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>30. Blood in urine</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>31. Diabetes</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>32. Headaches/migraine</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>33. Dizziness/fainting</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>34. Epilepsy</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>35. Joints/spinal trouble</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>36. Surgical operation</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>37. Serious accident/fracture</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>38. Tropical disease</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>39. Fear of heights</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>40. Rejected for employment or insurance for medical reasons</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>41. Awarded benefits for industrial injury/illness</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>42. Treated for a mental condition, e.g. depression</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>43. Treated for problem drinking or drug abuse</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>44. Exposed to toxic substance or noise</td> </tr> </table>		Y	N	<input checked="" type="checkbox"/>	21. Cancer	<input checked="" type="checkbox"/>	22. Heart Disease	<input checked="" type="checkbox"/>	23. Rheumatic fever	<input checked="" type="checkbox"/>	24. Abnormal heartbeat	<input checked="" type="checkbox"/>	25. High blood pressure	<input checked="" type="checkbox"/>	26. Stroke	<input checked="" type="checkbox"/>	27. Serious chest pain	<input checked="" type="checkbox"/>	28. Any blood disease	<input checked="" type="checkbox"/>	29. Kidney disease	<input checked="" type="checkbox"/>	30. Blood in urine	<input checked="" type="checkbox"/>	31. Diabetes	<input checked="" type="checkbox"/>	32. Headaches/migraine	<input checked="" type="checkbox"/>	33. Dizziness/fainting	<input checked="" type="checkbox"/>	34. Epilepsy	<input checked="" type="checkbox"/>	35. Joints/spinal trouble	<input checked="" type="checkbox"/>	36. Surgical operation	<input checked="" type="checkbox"/>	37. Serious accident/fracture	<input checked="" type="checkbox"/>	38. Tropical disease	<input checked="" type="checkbox"/>	39. Fear of heights	<input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise	<table border="1"> <tr> <th>Y</th> <th>N</th> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>HAVE YOU EVER BEEN:-</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>40. Rejected for employment or insurance for medical reasons</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>41. Awarded benefits for industrial injury/illness</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>42. Treated for a mental condition, e.g. depression</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>43. Treated for problem drinking or drug abuse</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>44. Exposed to toxic substance or noise</td> </tr> </table>		Y	N	<input checked="" type="checkbox"/>	HAVE YOU EVER BEEN:-	<input checked="" type="checkbox"/>	40. Rejected for employment or insurance for medical reasons	<input checked="" type="checkbox"/>	41. Awarded benefits for industrial injury/illness	<input checked="" type="checkbox"/>	42. Treated for a mental condition, e.g. depression	<input checked="" type="checkbox"/>	43. Treated for problem drinking or drug abuse	<input checked="" type="checkbox"/>	44. Exposed to toxic substance or noise	Y N
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FOR WOMEN ONLY Have you ever had:- <i>NA</i>																																																																				
45. An abnormal smear																																																																				
46. Any gynaecological treatment																																																																				
47. Are you pregnant?																																																																				
48. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE																																																																				
How much tobacco each day?		<i>no</i>	Average daily alcohol consumption <i>no</i>																																																																	
Have you ever taken elicited drugs? () PDO test all new/potential employees for elicited/recreational drugs																																																																				
FAMILY HISTORY: Diabetes <input checked="" type="checkbox"/> Tuberculosis <input checked="" type="checkbox"/> Epilepsy <input checked="" type="checkbox"/> Asthma <input checked="" type="checkbox"/> Eczema <input checked="" type="checkbox"/> Heart disease <input checked="" type="checkbox"/> High blood pressure <input checked="" type="checkbox"/> Stroke <input checked="" type="checkbox"/> Blood Disease <input checked="" type="checkbox"/> Cancer <input checked="" type="checkbox"/>																																																																				
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-																																																																				
I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer. I am also aware that PDO reserve the right to dismiss me if it was found that I have purposely withheld important medical information.																																																																				
Date: <i>29/3/19</i>		Signature of Applicant: <i>girij</i>																																																																		

FOR COMPLETION BY EXAMINING DOCTOR OR NURSE
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION										
N	A											
<input checked="" type="checkbox"/>	1. Eyes & Pupils											
<input checked="" type="checkbox"/>	2. E.N.T.											
<input checked="" type="checkbox"/>	3. Teeth & Mouth											
<input checked="" type="checkbox"/>	4. Lungs & Chest											
<input checked="" type="checkbox"/>	5. Cardiovascular System											
<input checked="" type="checkbox"/>	6. Abdo. Viscera											
<input checked="" type="checkbox"/>	7. Hernial Orifices											
<input checked="" type="checkbox"/>	8. Anus & Rectum											
<input checked="" type="checkbox"/>	9. Genito-urinary											
<input checked="" type="checkbox"/>	10. Extremities											
<input checked="" type="checkbox"/>	11. Musculo-skeletal											
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.											
<input checked="" type="checkbox"/>	13. C.N.S.											
HEIGHT cm		WEIGHT kg	BM I	B.P. 140 78	PULSE /mins.	HEARING L R	VISION				Colour Vision	Blood Group
156		64	26.90		78		Uncorrected	DISTANT R L	NEAR R L			
						Corrected						
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	LABORATORY AND OTHER SPECIAL INVESTIGATIONS										
		N A										
		7. Audiogram										
		8. Lung Function										
		9. Chest X-Ray										
		10. ECG <i>Multifocal</i>										
		11. CVS risk for 40 yrs. & above										
		12. HIV, Hepatitis screening										

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

Type 2 DM on medication, ECG: Multifocal VPIs - Ad physician/ Cardiologist
Triglycerine, Cholesterol, BP, Hb, Blood count, ESR, LFT, RFT, RBS, Drug Screen, Lipids (40 years +), Sickle Cell test

ASSESSMENT:

- FIT ALL AREAS *1/5/19*
- FIT WITH SPECIFIC RESTRICTION
- TEMPORARY UNFIT
- AWAITING SPECIALIST ASSESSMENT

* Framingham Risk Score : 5%

REVIEW/CONSULTATION

DATE: *02/04/19*



Seen by cardiologist in
Badar Al-Salam, Elwadde
and fit to work
on 21/4/19

SIGNATURE: *[Signature]*