

Hand Arm Vibration (HAV) Pre-Exposure and Annual Self-Assessment

- The data collected below is for the sole purpose of recording potential or actual impact to health through HAV. The data will be protected in accordance with DPA18 and MOD policy.
- Questions 1 to 19 are to be completed before exposure.
- Questions 6 to 24 are to be completed for Annual assessment.
- Please complete in block capitals.

Guidance: Questions 1-5 only apply for pre-exposure assessment			
1	Have you ever used hand-held vibrating tools, machines or hand-fed processes in your job?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2	If 'Yes', what was the year of first exposure?		
3	When was the last time you used vibrating tools or machines?		
4	Have you ever had any serious disease of joints, skin, nerves, heart or blood vessels that could be adversely affected by using vibrating hand tools?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5	Have you ever had any neck, arm or hand injury or operation that could be adversely affected by using vibrating hand tools?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Guidance: Questions 6-19 apply for pre-exposure and annual assessment			
6	Have you been using hand-held vibrating tools, machines or hand fed processes in your job, or if this is a review, since your last assessment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

For annual assessment only, if you answer NO to question 6 or it is more than 2 years since last exposure there is no requirement to answer further questions - inform your commander or manager and follow the process detailed in guidance note for forwarding of completed forms.

7	Are you suffering from loss of grip strength in your hands and/or do you have pain in your wrist and arm?										Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If 'Yes', please describe the severity of the pain experienced											
	No pain						Pain as bad as it could be					
	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>	10 <input type="checkbox"/>	
8	Do you feel that the sensation of touch in any of your fingers has decreased?										Yes <input type="checkbox"/>	No <input type="checkbox"/>
9	Do you believe you are being exposed to harmful levels of vibration?										Yes <input type="checkbox"/>	No <input type="checkbox"/>
10	Do you think that vibrating equipment supplied is not operating effectively and/or not being maintained correctly? (A 'No' answer means that you are satisfied with their operation and maintenance)										Yes <input type="checkbox"/>	No <input type="checkbox"/>

11	Do you have tingling in your fingers/or your fingers go numb for more than 20 minutes after using vibrating equipment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																							
12	Do you have numbness or tingling of your fingers at any other time?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																							
13	Do you wake at night with pain, tingling or numbness in your hand or wrist?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																							
If 'Yes', please describe the severity of the pain experienced																										
<table border="1"> <tr> <td colspan="5">No pain</td> <td colspan="7">Pain as bad as it could be</td> </tr> <tr> <td>0 <input type="checkbox"/></td> <td>1 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>3 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>5 <input type="checkbox"/></td> <td>6 <input type="checkbox"/></td> <td>7 <input type="checkbox"/></td> <td>8 <input type="checkbox"/></td> <td>9 <input type="checkbox"/></td> <td>10 <input type="checkbox"/></td> </tr> </table>				No pain					Pain as bad as it could be							0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>	8 <input type="checkbox"/>	9 <input type="checkbox"/>	10 <input type="checkbox"/>
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14	Have you ever suffered from your fingers going white* and numb with exposure to cold? See picture and description below.	Yes <input type="checkbox"/>	No <input type="checkbox"/>																							
15	If 'Yes' to question 14, do you have difficulty re-warming them when leaving the cold?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																							
16	Have you noticed any change in your response to your tolerance for working outdoors in the cold?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																							
17	Are you experiencing any other problems in your hands or arms?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																							
18	Do you have difficulty picking up small objects such as screws or buttons or difficulty opening tight jars?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																							
19	Are you experiencing any other problems with the muscles or joints of your hands or arms that could be adversely affected by using vibrating hand tools?	Yes <input type="checkbox"/>	No <input type="checkbox"/>																							
If you have answered 'Yes' to Questions 4, 5, 17, and/or 19, please give details in box below (continue on a separate sheet if necessary).																										

* The picture below shows an example of finger whiteness. Whiteness means a clear discolouration of the fingers with a sharp edge, usually followed by a red flush.



Guidance: questions 20-24 apply to annual assessment only					
20	Have you previously reported any of the symptoms detailed above?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
21	If you answered Yes to question 20, have the symptoms been investigated by a Service Medical Officer, General Practitioner or Occupational Health Specialist		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
22	Was an Occupational Health Assessment carried out?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
23	If health surveillance or health monitoring recommendations were raised as part of the Occupational Health assessment, have all recommendations been actioned? If you answer NO advise your commander or manager of all outstanding action.		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
24	Do you consider a further referral to Occupational Health is required?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Previous job history (continue on a separate sheet if necessary)					
Job title / Function		Did it involve vibration?		From (year)	To (year)
		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Declaration					
I confirm that the information given above is accurate to the best of my knowledge					
Name					
Date					
Signature					

Guidance Notes (MOD Form 5053 Annex A)**Completing the form:**

For Pre-exposure assessment, complete questions 1 to 19.

For Annual assessment, complete questions 6 to 24.

For staff:**Positive Response**

Pre exposure: If you answered 'Yes' to questions 4 to 19 and your pain rating in questions 7 or 13 is above 5 or if your pain rating is below 5 for three consecutive assessments, you will need to inform your commander or manager (you are not required to show your commander or manager the form). Your commander or manager will make arrangements to refer you to occupational health service provider for an assessment.

Annual assessments: If you answered 'Yes' to questions 6 to 24 you will need to inform your commander or manager (you are not required to show your commander or manager the form. However, to enable them to decide if arrangements need to be made to refer you to your occupational health service provider, it will be necessary to provide your answers to questions 21 to 24, failure to disclose this information could limit the action the commander or manager can take).

This questionnaire must be taken with you to your appointment with your occupational health provider and a copy will be retained by them.

Negative Response

If you have answered 'No' to questions 1 and 4 to 24, inform your commander or manager that you have completed the assessment and you have answered No to the questions asked (you are not required to show your commander or manager the form).

The completed form is to be posted or e-mailed (marked "Official Sensitive Personal HAVS Assessment") to your occupational health service provider.

For commanders and managers:

You do not have an automatic right to see the completed form.

Pre exposure assessment: If personnel advise you that they have given a positive response for Hand Arm Vibration, you **must** refer them to your occupational health service provider for further action. They will advise you accordingly on any recommended changes (such as equipment, work processes and so on) necessary to mitigate risk.

Annual assessments: If personnel advise you that they have given a positive response for Hand Arm Vibration, you are to request the member of staff to provide the details recorded for questions 20 - 24, which will allow you to determine whether the member of staff should be referred for an occupational health assessment. If personnel decline to disclose this information, this limits the commander's or manager's options and the member of staff should be referred for an occupational health assessment. The occupational health service provider should assess your personnel and advise you accordingly on any recommended changes (such as equipment, work processes and so on, necessary to mitigate any risk).

If a member of staff is dissatisfied with the operation or maintenance of equipment (question 10), you must investigate and ensure that all equipment is properly maintained and operating correctly.

Record all actions taken in the person's Personal Health Record under 'Actions taken.'

For occupational service providers:

Records, including risk assessments and health records, **must** be retained in accordance with JSP 375, Volume 1, Chapter 39 (Retention of records) and Chapter 14 Health Surveillance and Health Monitoring.

JSP 375, Volume 1, Chapter 39 Annex A identifies the following:

General HS and HM records must be retained for a minimum of 60 years from the date of the last entry.

Risk assessments associated with hazards, such as asbestos or noise and so on, that might take many years to become evident, must be retained for a minimum of 60 years.