SIGNS AND SYMPTOMS CHECK-LIST
Medical Record

Employee’s Name: _________________________ Title/Position: ________________________

Work #: __________________________________ Shift:_______________________________

Supervisor:_________________________ Title/Position:________________________

Work #: __________________________________ Shift:_______________________________

HR’s Name: ______________________________ Title/Position:________________________

Work #: __________________________________ Shift:_______________________________

Incident: ________________________________________________________________

________________________________________________________________________

Behavioral Changes Observed

_____ Rapid Mood Changes (sadness, euphoria)
_____ Aggressiveness
_____ Inappropriate Topics of Conversation
_____ Irritability
_____ Rambling Flow of Thoughts and Speech
_____ Loud or Disinhibited Speech (singing, yelling)
_____ Restlessness
_____ Sleepiness
_____ Slurred Speech

Physical Changes Observed

_____ Lack of coordination/Unsteady Gait
_____ Flushed Face
_____ Alcohol Smell on Breath

I certify that the enclosed information is true and to the best of my knowledge.

_________________________       _______ _________________________       _______
Employee         Date  Management            Date

_________________________       _______
Witness            Date

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BASIC ON-SITE COORDINATION EXAMINATION

Medical Record

1. Employee Name: ____________________________________________________________

2. Employee consent to Coordination Exam _____________________________________
   Employee Signature

3. Balance: (Eyes closed/One foot/Head back/etc.) _____ Sways while balancing _____ Falling _____ Staggering _____ Sagging Knees _____
   Puts foot down _____ Can’t do test at all _____


5. Finger to Nose: Right/Missed _____ Hesitant _____ Normal _____
   Left/Missed _____ Hesitant _____ Normal _____

Signed By: ___________________________ Date: ____________________________

Corporate Care/Employee Health
Professional or Designee
QUESTIONS FOR SUSPECTED SUBSTANCE ABUSERS

Medical Record

Employee Name: _____________________ Employee Social Security #: __________

1. Did you drink alcohol or an alcoholic beverage today? _______ IF yes, What did you drink? ____________; How much? ____________; When did you start? _______________; When did you stop? _______________; Where did you drink? ________________; With whom did you drink? _________________.

2. Are you using any type of drug? __________ If yes, what? ____________________

3. Are you feeling ill? ________________ If yes, what are your symptoms?

__________________________________________________________________________

4. Are you under doctor’s care? __________ If yes, what are you being treated for?
   ________________; What is your doctor’s name and address?
   _________________________________________________________________________
   When last did you visit the doctor? _________________

5. Are you taking any medication? ___________ What medication? ___________________
   _______________; Who prescribed? ________________; When did you take your last dosage? ______________;
   Do you have your prescription in your possession? ________________; Do you have any additional medication in your possession? ________________;
   Record all information regarding prescription? take sample, if permitted by Employee.

6. Do you have any pre-existing medical problems?
   Diabetes? ____________; Are you taking insulin? _________________
   Do you have low blood sugar? ____________; Epileptic? _________________

7. Do you have a cold? ________________ If yes, are you taking any cold pills?
   ________________; Cough medicine? ________________
   Antihistamines? _________________

8. Would you submit to basic coordination tests? _________________

9. Would you submit to a physical examination to include a blood and/or urinalysis by a health official so we can be sure that you are in good health and able to safely perform you job? ___________ If no, reasons for refusal.

__________________________________________________________________________

Signed By: _________________________ Date: ______________

Corporate Care/Employee Health Professional or Designee
# OBSERVATION CHECK LIST

## Medical Record

1. **Employee Name:** _________________________________________________________

2. **Walking**
   - Stumbling ____
   - Staggering _____
   - Falling ______
   - Unable to _____
   - Swaying ____
   - Unsteady _____
   - Holding on ______

3. **Standing**
   - Swaying ____
   - Rigid _____
   - Unable to stand ____
   - Feet wide apart ____
   - Staggering ____
   - Sagging at knees _____

4. **Speech**
   - Shouting ____
   - Silent ____
   - Whispering ____
   - Slow ____
   - Rambling _____
   - Mute ____
   - Slurred ____
   - Slobbering ____
   - Incoherent ____
   - Confused ____
   - Normal _____

5. **Demeanor**
   - Cooperative ____
   - Polite _____
   - Calm ____
   - Sleepy ____
   - Crying ____
   - Silent ____
   - Talkative _____
   - Excited ____
   - Sarcastic ____
   - Fighting ____
   - Alert ____

6. **Actions**
   - Resisting communications ____
   - Fighting ____
   - Threatening ____
   - Calm ____
   - Drowsy ____
   - Profanity ____
   - Hyperactive ____
   - Hostile _____
   - Erratic _____

7. **Eyes**
   - Bloodshot ____
   - Watery ____
   - Dilated ____
   - Glassy ____
   - Droopy _____
   - Closed ____

8. **Face**
   - Flushed _____
   - Pale ____
   - Sweaty ____

9. **Appearance**
   - Unruly ____
   - Messy ____
   - Dirty ____
   - Partially dressed ____
   - Bodily excrement stains ____

10. **Clothing**
    - Stains on clothing ____
    - Neat ____
    - Having odor ____

11. **Breath**
    - Alcoholic odor ____
    - Faint alcoholic odor ____
    - No alcoholic odor _____

12. **Movements**
    - Fumbling ____
    - Jerky ____
    - Slow ____
    - Normal ____
    - Nervous ____
    - Hyperactive ____

13. **Eating/Chewing**
    - Gum ____
    - Candy ____
    - Mints ____
    - Other- identify if possible ______________________________________

14. **Other Observations (Unusual actions)**

    ______________________________________
    ______________________________________
    ______________________________________
    ______________________________________

Signed By: ___________________________________         Date: _________________________

Corporate Care/Employee Health
Professional or Designee
Employee Name: _________________________________________________________

1. Unfit for work __________________________________________________________

2. Recommended for substance abuse screening ________________________________

3. Does not appear to be under influence of alcohol ____________________________

4. Does not appear to be under the influence of drugs __________________________

5. Not recommended for substance abuse screening _____________________________

Additional Remarks if any: _________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Signed By: ___________________________ Date: ________________________________

Corporate Care/Employee Health Professional or Designee
RETURN TO WORK AGREEMENT REGARDING _________________________

Name of Employee

herein, referred to as “I”, was suspended without pay from employment at ____________________________ and, in consideration for the promises contained herein, shall be permitted to return to work on _________________________ under the following conditions:

1. a. I am currently enrolled in, and shall continue my participation in, the drug treatment program recommended for me by __________________ until completing same to the satisfaction of the Program Director.

b. Beginning on ____________________, I shall provide ______________________, with monthly documentation of attendance and continuing compliance with the Center’s outpatient drug treatment program until I complete said program, as set forth above.

c. I further understand that my designated counselor at __________________ may recommend periodic drug testing as part of my treatment and I agree to comply with all such recommendations. Further, I understand and agree that my facility shall have the right to require me to submit to periodic drug tests during the two-year period following my return to work on ____________ and I agree to provide specimens for and otherwise submit to such testing. In addition, I understand and agree that the testing recommend by my drug treatment counselor and/or required by __________________ may include blood and/or urine tests and that the required specimen will be obtained at ________________ or another facility designated by the RWJBH.

d. I hereby authorize my counselor or other designated counselors at ______________ to release information concerning my progress in the program to ________________.

e. I hereby agree to execute any release required by medical personnel in connection with each and every recommended or facility required drug test.

f. I hereby authorize the release to the facility of the results of each and every recommended or RWJBH required drug test.

g. I understand that information concerning this RETURN TO WORK AGREEMENT and the implementation and monitoring of my compliance there with will be disseminated to various persons associated with and/or employed by RWJBH and ________________ and I hereby authorize such dissemination.

2. I agree that any positive drug test or failure or refusal by me to comply with the terms of the RETURN TO WORK AGREEMENT shall result in my immediate discharge and shall constitute just cause for my discharge.
3. a. I understand and agree that this RETURN TO WORK AGREEMENT is not intended to create any obligation on the part of the facility to continue my employment for a specified period of time and does not otherwise prohibit the facility from terminating my employment for reasons generally applicable to all employees.

b. I hereby release, waive and give all claims, under state, federal or common law, that I had, now have, or may have in the future against the facility, its agents, employees and/or representatives arising out of the suspension of my employment between ________________ and ________________.

By their signature, ____________________________________, indicates their understanding and acceptance of all the conditions outlined above.

Dated: ________________________________, 20__

Dated: ________________________________, 20__
Medical Record

I, ______________________________, understand that I have been asked to undergo a medical examination that includes:

(   ) blood test for substance abuse (drug/alcohol)
(   ) urine test for substance abuse (drug/alcohol)

I understand that if I refuse to sign this consent and refuse to take the test for substance abuse, the medical examination will not be complete. The applicable RWJBarnabas Health affiliate Human Resources Department will be so notified, and if I am an applicant for employment, my application for employment will be rejected, and if I am already a RWJBarnabas Health employee, I may be subject to disciplinary action in connection with RWJBarnabas Health Substance Abuse Policy.

I understand that if I do consent to the test for substance abuse, the results of my substance abuse test will be reported to the applicable RWJBarnabas Health affiliate Human Resources Department. If I am not yet an employee of a RWJBarnabas Health affiliate, and I test positive for substance abuse, my offer for employment will be rescinded, but an exception may be made for use of legally prescribed medication taken under the direction of a physician, at the discretion of a Corporate Care/Employee Health physician. If I am already an employee of a RWJBarnabas Health affiliate, and I test positive for substance abuse, my positive test results may result in disciplinary action, up to and including termination, subject to discretionary exceptions for use of legally prescribed medications.

CHECK ONE OF THE FOLLOWING:

(   ) I do not consent to submission to a medical examination including test(s) for substance abuse.

(   ) I hereby consent to the performance of a medical examination including the test(s) for substance (drug/alcohol) abuse which will be forwarded to an independent laboratory. Further, I give the independent laboratory my permission to release the results of my substance abuse test(s) to the Human Resources Department of RWJBarnabas Health affiliate where I am currently employed, or to which I am currently applying for employment. I hereby release RWJBarnabas Health, its affiliates, trustees, officers, medical staff, employees and agents from any and all claims or causes of action resulting from the performance of this substance abuse test, and the release of information regarding the test results.

_____________________________________ ____________________________________
Signature of Employee/Prospective Employee  Date

_____________________________________ ____________________________________
Signature of Witness      Date