

	STANDARD CHECKLIST	Document ID:	TNCL-OHS-CHK-0019
		Document owner	OHS Manager
	FATIGUE SYMPTOMS CHECKLIST	Revision	02
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FATIGUE SYMPTOMS CHECKLIST

Employee Name:	Date:
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How did the person come to your attention?

Direct observation of a person's behaviour or performance
 Self-report of fatigue
 Other individuals raised concerns regarding a person's fatigue or performance.
 Other _____

Did the person show any of the following signs of fatigue?

<p>Appearance</p> <input type="checkbox"/> Bloodshot eyes <input type="checkbox"/> Poor coordination <input type="checkbox"/> Frequent blinking <input type="checkbox"/> Long eye blinks <input type="checkbox"/> "Droopy" eyelids <input type="checkbox"/> Slow or disjointed speech <input type="checkbox"/> Repeated yawning	<p>Driving</p> <input type="checkbox"/> Drifting across lanes <input type="checkbox"/> Erratic steering <input type="checkbox"/> Forgot to dip the lights. <input type="checkbox"/> Varied speed without noticing. <input type="checkbox"/> Missed turnoff/traffic signs
<p>Mood</p> <input type="checkbox"/> Irritable/short tempered <input type="checkbox"/> Argumentative <input type="checkbox"/> Impatient <input type="checkbox"/> Poorly considered decisions. <input type="checkbox"/> Overfocus on minor issues	<p>Performance</p> <input type="checkbox"/> Loss of attention <input type="checkbox"/> Difficulty following instructions. <input type="checkbox"/> Request repeat for instructions. <input type="checkbox"/> Reduced ability to think clearly. <input type="checkbox"/> Poor anticipation <input type="checkbox"/> Automatic or repetitive ("zombie-like") behavior

Are there any other factors that could make the situation worse?

Currently on nightshift
 Undertaking potentially hazardous work
 On the first shift back after early awakening / long commute to the site
 On the first night shift, not had an afternoon sleep.
 Medication (prescription, over-the-counter, herbal)
 Other

General Comments:

Supervisor Name / Signature: