CONFIDENTIAL

YEHS/ENG1/HDTEB35

Date: _____

GP

Dear colleague,

Request for Detailed Medical Information – Asthma and Seafarer Fitness Assessment

Name: _____

Date of Birth: _____

Your patient has applied for an ENG1 seafarer medical certificate and has declared asthma. I am assessing the likelihood of acute respiratory impairment or incapacitation while at sea, where medical facilities and emergency evacuation may be limited or delayed. I would therefore be grateful for a detailed factual medical report addressing the following.

Please confirm:

1. Diagnosis and onset

- The diagnosis, age at onset and whether asthma was childhood- or adult-onset.
- The basis for diagnosis.
- Whether the condition is mild, moderate or severe; whether it is exercise-induced only; and its current level of control (this information is very important for me). (see reference below)
- Whether an Asthma Control Test or equivalent validated assessment has been undertaken, with the score and date if available.

2. Pattern, severity and triggers

- The number, dates and severity of exacerbations in the past five years, particularly the past two years.
- Whether there is evidence of worsening severity between episodes.
- The usual pattern and duration of episodes, including any unpredictable episodes of severe breathlessness.
- Known provoking factors, including respiratory infection, exercise, cold air, smoke, dust, fumes, chemicals, cleaning products, paints, animals, mould, flour, latex or other irritants/sensitisers.

- Whether there is allergic asthma or another significant allergic cause; the identified allergen(s); and whether complete avoidance is required to prevent recurrence.

3. Treatment and self-management

- Current and recent asthma treatment, including all reliever and preventer inhalers, dose, frequency, prescribed regimen, and adherence where known.

- Frequency of short-acting beta-agonist/reliever inhaler use over the past 12 months, specifically whether use exceeds two days per month.

- Whether preventer medication is taken regularly or intermittently.

- Any oral medication used for asthma, including oral corticosteroids, leukotriene-receptor antagonists or other agents.

- Details of each oral corticosteroid course in the last three years: date, dose/duration, indication and whether there was objective deterioration in symptoms or peak expiratory flow.

- Whether oral steroids were prescribed solely as a precaution during a respiratory tract infection without worsening asthma symptoms.

- Whether the patient self-manages acute episodes, has a written asthma action plan, carries medication reliably and has demonstrated effective inhaler technique.

4. Significant events and escalation

- Any asthma-related hospital admission, emergency department attendance, urgent GP review, emergency nebuliser treatment, injected bronchodilators, intensive-care admission, ventilation or life-threatening episode, with dates.

- Any sleep disturbance due to asthma, persistent morning symptoms, or exercise/activity limitation.

- Any episode in which symptoms failed to respond to usual treatment.

5. Objective evidence and specialist input

- Latest spirometry and peak-flow results, including date, predicted values, bronchodilator reversibility, personal-best peak flow where known, and any relevant serial peak-flow records.

- Any respiratory specialist or occupational-health assessment, with copies of relevant reports where available.

- If severity or diagnostic certainty remains unclear, whether respiratory referral and bronchial challenge testing would be clinically appropriate.

6. Please advise and provide information if occupational asthma is known or suspected.

7. Overall clinical opinion

- Whether the asthma is currently stable and effectively controlled.
- The anticipated risk of an acute exacerbation or significant breathlessness during work at sea.
- Whether, in your clinical opinion, the patient can safely undertake safety-critical duties in a remote maritime setting, with limited immediate medical support.

I understand you may not be able to answer every question above, but would appreciate as much information as you can provide. Please attach recent prescribing records, spirometry/peak-flow reports, relevant hospital discharge summaries and respiratory specialist correspondence where available.

With kind regards,

Ade Buluro

Dr. Ade Buluro
Mb.Ch.B (Ogun), MRCGP, DipOccMed, MRO,
GP / Family Doctor / Family Physician / Occupational Health Doctor

Your Excellent Health Service
25 Harley Street, LONDON, W1G 9QW
TEL: 020 4617 6186
MOB: 07481 342 578
EMAIL: adeolab@yourexcellenthealth.org
WEBSITE: www.yourexcellenthealth.org
LINKTREE: https://linktr.ee/yehsofficial
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Reference:

Childhood Asthma

Mild – few or no hospitalisations, normal activities between episodes, controlled by inhaler therapy alone, remission before age 16, normal lung function

Moderate – few hospitalisations, frequent use of reliever inhaler between episodes, interference with normal exercise activity, remission before age 16, normal lung function

Severe – frequent episodes requiring treatment to be made more intensive, regular hospitalisation, frequent oral or iv steroid use, lost schooling, abnormal lung function

Adult Asthma

Asthma may persist from childhood or start over the age of 16. There is a wide range of intrinsic and external causes for asthma developing in adult life. In late entry recruits with a history of adult onset asthma the role of specific allergens, including those causing occupational asthma should be investigated. Less specific inducers such as cold, exercise and respiratory infection also need to be considered. All can affect fitness for work at sea.

Mild intermittent asthma – infrequent episodes of mild wheezing occurring less than once every 2 weeks, readily and rapidly relieved by beta agonist inhaler.

Mild asthma – frequent episodes of wheezing requiring use of beta agonist inhaler or the introduction of a corticosteroid inhaler. Regular use of a preventer inhaler may effectively eliminate symptoms and the need for more than occasional use of a rapid acting bronchodilator reliever inhaler.

Exercise induced asthma – episodes of wheezing and breathlessness provoked by exertion especially in the cold. Episodes may be effectively controlled by either long-term preventer inhalers, short term reliever inhalers used prior to or during exercise or by oral medication.

Moderate asthma – frequent episodes of wheezing despite regular use of inhaled steroid (or steroid/long acting beta agonist) treatment requiring continued use of frequent beta agonist inhaler treatment, or the addition of other medication, occasional requirement for oral steroids. f

Severe asthma – frequent episodes of wheeze and breathlessness, frequent hospitalisation, frequent use of oral steroid treatment. f

Reactive Airway Dysfunction Syndrome – onset over age 16 following chemical inhalation incident. This is characterised by non-specific airway hyper-reactivity brought on by irritants, cold etc and will follow a single severe overexposure to an irritant such as chlorine or ammonia. It is likely to limit fitness for work at sea.