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| **WorkSafe Health Monitoring Form** **Notification: ASBESTOS** |

**CONFIDENTIAL** [ ]  **MINING** [ ]  **GENERAL**

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| **1. EMPLOYER DETAILS** (also called a Person Conducting a Business or Undertaking – PCBU) |
| Company / Organisation name:       |
| Address:       | Tel:       |
| Contact name:       | Email:       |
| **2. LABOUR HIRE / CONTRACTOR DETAILS** (if applicable) |
| Company / Organisation name:       |
| Address:       | Tel:       |
| Contact name:       | Email:       |
| **3. WORKER DETAILS (X) all relevant boxes** |
| Family name:       | Given names:       |
| Date of birth:       | [ ]  Male [ ]  Female |
| Country of birth:       |
| Address:       |
| Mobile:       | Email:       |
| GP details: Dr Name:       Tel:      Medical Practice:      Address:       |
| Job:       Date started:       |
| Working in mining or on a mine site [ ]  Yes [ ]  No |
| Yes, name of mine site:       Name of mining company:       |

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| **4. EXPOSURE TO ASBESTOS** (to be completed by the worker) **(X) all relevant boxes** |
| 4A [ ]  Ongoing asbestos risk-work  | Dates:      /     /      -      /     /      |
| Description of Asbestos Exposure:  |
| 4B [ ]  Incident (Single exposure to asbestos) | Dates:      /     /      |
| Description of Asbestos Exposure:  |
| **5. WORKPLACE CONTROLS (X) all relevant boxes** |
| Personal Protective Equipment (PPE)Disposable Overalls [ ]  No [ ]  YesGloves [ ]  No [ ]  YesLaceless boots [ ]  No [ ]  Yes | Precautions e.g. wet work:      Comments:       |
| Respiratory Protective Equipment (RPE) provided by Employer [ ]  Yes [ ]  NoRPE use: [ ]  All the time [ ]  Mostly (3/4 time) [ ]  Often (1/2 time) [ ]  Sometimes (1/4 time) [ ]  Never / rarely |
| RPE Type[ ]  Disposable half-face mask – nuisance dust type[ ]  Disposable half-face mask – P1 or P2/N95 standard[ ]  Reusable respirator [ ]  half-face [ ]  full-face | [ ]  Powered air purifying respirator (PAPR) [ ]  tight fitting full facepiece [ ]  loose fitting full facepiece [ ]  hood or helmet[ ]  Supplied air respirator Air quality tested [ ]  Yes [ ]  No |
| RPE Fit Testing [ ]  Yes [ ]  No |
| Personal HygieneClean shaven [ ]  Yes [ ]  NoWash hands & face before eating / drinking [ ]  Yes [ ]  NoShower & change into clean clothes at end of shift [ ]  Yes [ ]  No |

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| **6. ASBESTOS EXPOSURE HISTORY** (to be completed by worker) |
| Year of first exposure to asbestos       |
| Non-work asbestos exposure: [ ]  No [ ]  Yes, when:      If Yes, describe exposure:       |
| From (Mth/ Yr) | To (Mth/Yr) | Employer Name | Employer Address | Job Title and Work Tasks  | Asbestos exposure (Yes / No) |
|       |       |       |       |       |       |
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| Comment:       |
| **7. MEDICAL HISTORY** (to be completed by registered medical practitioner) **(X) all relevant boxes** |
| 1. Previous Chest Imaging[ ]  No[ ]  Yes, Date:       Radiology Provider:       | Comment by RMP:       |
| 2. Smoking history:  | Current smoker [ ]  | Ex-smoker [ ]  | Never smoked [ ]  |
| Age started:       | Age stopped:       | Amount smoked:       per day |
| 3. Respiratory symptoms e.g cough, shortness of breath, wheeze, phlegm (describe):       |
| 4. Any | [ ]  Asthma  | [ ]  Pneumonia | [ ]  Bronchitis  | [ ]  Other lung/chest disease or injury |
| If yes, provide details (diagnosis, when, treatment):  |
| 5. Any other relevant health problems? [ ]  Yes [ ]  No | Comment by RMP:       |
| 6. List any current medications:        |

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| **8. MEDICAL EXAMINATION** (to be completed by registered medical practitioner) |
| Respiratory Findings:       | Other relevant findings:         |
| Summary assessment:       |
| **9. IMAGING** (to be completed by registered medical practitioner)  Attach report |
| Chest X-ray (CXR)Required [ ]  Not Required [ ] Note: *A CXR is* ***not*** *routinely recommended for a single minor event or potential exposure – but may be ordered where clinically indicated.* | CXR Results (if required) Provider:  |
| Low dose CT Scan (LDCT)Required [ ]  Not Required [ ]  Note: *A LDCT is* ***not*** *routinely recommended for a single minor event or potential exposure – but may be ordered where clinically indicated.*Note: *Recommended on exit for those with first exposure at least 20 years ago.* | LDCT Results (if required): Provider:  |

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| **10. LUNG FUNCTION TESTS**  **Registered medical practitioner to complete and (X) all relevant boxes**  **Attach spirometry printouts, graphs, report.**  |
| 1. Attach printouts with 3 valid tests (which meet ATS “satisfactory blow” criteria) and the corresponding flow-volume graphs.
2. If submitting pre and post-bronchodilator spirometry, please clearly mark the print-outs.
3. Enter best test values below:
 |
| Enter Best Readings | Date | FEV1 | FVC | FEV1 / FVC (%) | **Comment:** |
| Current test |       |       |       |       | [ ]  Normal [ ]  Abnormal |
| % Predicted |  |       |       |  | [ ]  Obstructive [ ]  Restrictive |
| Baseline |       |       |       |       | [ ]  Mixed Obstructive / Restrictive  |
| % Predicted |  |       |       |  |  |
| **Comments** (examining doctor) |
| **11. ASSESSMENT (X) all relevant boxes** |
| 1. Worker’s personal hygiene [ ]  Satisfactory [ ]  Not satisfactory
2. Worker’s workplace controls are [ ]  Satisfactory [ ]  Not satisfactory [ ]  Uncertain
3. Respiratory assessment [ ]  Satisfactory [ ]  Not satisfactory

 [ ]  Requires assessment by respiratory physician  |
| **Comments:**  |

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| **12. RECOMMENDATIONS – Registered medical practitioner to complete (X) all relevant boxes** |
| 1. [ ]  Suitable for work with asbestos with effective safety controls including respiratory protection & dust

 suppression1. [ ]  Uncertain of suitability for work with asbestos
2. [ ]  Remove from exposure to asbestos *(RMP to notify WorkSafe promptly – call 1300 307 877)*
3. [ ]  More tests:
4. [ ]  Referral to Respiratory Physician for assessment and clinical advice

 Respiratory Physician (name):       *(RMP to forward Respiratory Physician report to WorkSafe Occupational Physician promptly)*1. **Actions**

[ ]  Explain results to worker (and potential adverse health effects)[ ]  Reinforce importance of personal hygiene and use of respiratory protective equipment[ ]  Advise to stop smoking[ ]  Inform Employer of outcome of health surveillance [ ]  Inform Employer to review and implement controls in workplace7. **Next review date**:       |
| Comments:  |
| **13. Registered Medical Practitioner** (examining doctor) |
| Name:       | Signature:       | Date:      /     /      |
| Medical Practice address:       |
| Email:       |
| AHPRA registration number:       |
| [ ]  Discussed with WorkSafe Occupational Physician (where required only) on:      /     /      |
| **Instructions for submission to DMIRS** |
| Check all sections of the form have been completedAttach relevant reports (spirometry, pathology, radiology, medical specialist)Submit via:* Email to safety@dmirs.wa.gov.au or
* Send to Occupational Physician, WorkSafe, Locked Bag 100, EAST PERTH WA 6892
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To contact WorkSafe Occupational Physician or Occupation Health Nurse, call 1300 307 877