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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  Yes  Gloves  No  Yes  Laceless boots  No  Yes | Precautions e.g. wet work:  Comments: | |
| Respiratory Protective Equipment (RPE) provided by Employer  Yes  No  RPE 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 Hygiene  Clean shaven  Yes  No  Wash hands & face before eating / drinking  Yes  No  Shower & 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   suppression   1. 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 workplace  7. **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 completed  Attach relevant reports (spirometry, pathology, radiology, medical specialist)  Submit via:   * Email to [safety@dmirs.wa.gov.au](mailto:safety@dmirs.wa.gov.au) or * Send to Occupational Physician, WorkSafe, Locked Bag 100, EAST PERTH WA 6892 | | |

To contact WorkSafe Occupational Physician or Occupation Health Nurse, call 1300 307 877