

Respiratory Health Monitoring

1. Person conducting a business or undertaking

Company/Organisation name

Site address

Suburb/Town

State

Postcode

Site phone

Contact name

Email

2. Work environment assessment *(tick all relevant boxes)*

Date of assessment *(DD/MM/YYYY)*

Crystalline silica industry

<input type="checkbox"/> Excavation/Earth moving	<input type="checkbox"/> Drilling Plant	<input type="checkbox"/> Clay/Stone Processing
<input type="checkbox"/> Paving/Surfacing	<input type="checkbox"/> Mining	<input type="checkbox"/> Construction
<input type="checkbox"/> Abrasive Blasting	<input type="checkbox"/> Foundry Casting	<input type="checkbox"/> Engineered stone
<input type="checkbox"/> Natural stone	<input type="checkbox"/> Other (specify)	<input type="text"/>

Controls

Respirator use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Local exhaust ventilation (if indoors)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Overalls / work clothing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Laundering by employer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wash basins & showers (with hot and cold water)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Wet handling methods used when possible	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Personal Hygiene

Clean Shaven	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Shower and change into clean clothes at end of shift	<input type="checkbox"/> Yes	<input type="checkbox"/> No

3. Other businesses or undertakings engaging the worker

Company/Organisation name

4. Worker details

(Please complete the details before you see the doctor. Please use print format.)

Surname

First name

Date of birth (DD/MM/YYYY)

Sex

Male

Female

Email

Telephone no.

Mobile no.

Postal address

Suburb

State

Postcode

Preferred language if not english

Current job

Date started employment

5. Employment in crystalline silica risk work

Please tick relevant boxes

New to crystalline silica work (less than one year work with crystalline silica)

Is this pre-employment?

Yes

No

New worker but not new to crystalline silica work (at this job less than one year but also worked previously with silica)

Current worker continuing in crystalline silica work

Current worker finishing a project

Is this exit-medical?

Yes

No

Worked with crystalline silica since (DD/MM/YYYY)

Satisfactory personal hygiene (for example nail biting, frequency of hand washing)

Yes

No

Risk assessment completed

Yes

No

Previous employment

Have you worked in other workplaces where you may have been exposed to asbestos or silica?

Yes

No

If Yes, please provide the details below or to our medical staff prior to the commencement of your examination.

Number of years	Type of industry	Occupation or job	Company

Medical history

Medical condition		Office use only
Have you had chest or abdominal surgery in the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Facial or eye surgery in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had a pneumothorax / collapsed lung?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional comments *(please provide any additional comments about your work/health)*

General practitioner's (GP) details

GP's Name

Medical centre *(if applicable)*

Phone no.

Address

Suburb

State

Postcode

The respiratory health monitoring examination includes:

- A chest x-ray
- Spirometry (Breathing test)
- A physical examination with emphasis on the respiratory system.

Privacy

Under the *Work Health and Safety Regulation 2017* (NSW), the person conducting a business or undertaking (PCBU) named at the start of this questionnaire is required to ensure their workers undergo health monitoring. In addition, they are required to obtain a health monitoring report in respect of those workers. That PCBU has engaged the Workers' Compensation (Dust Diseases) Authority (icare Dust Diseases Care) to conduct this health monitoring, which icare Dust Diseases Care has arranged to be undertaken by a registered medical practitioner.

icare Dust Diseases Care needs to collect, store, use and disclose your personal and health information in order to conduct the health monitoring with the relevant registered medical practitioner and provide the results of the health monitoring in a health monitoring report to the PCBU named at the start of this questionnaire. That health monitoring report will contain the following personal and health information:

- your name and date of birth
- the date of the health monitoring
- any test results that indicate whether or not you have been exposed to a hazardous chemical
- any advice that test results indicate that you may have contracted a disease, injury or illness as a result of carrying out the work that triggered the requirement for health monitoring
- any recommendation that the person conducting the business or undertaking take remedial measures, including whether you can continue to carry out the type of work that triggered the requirement for health monitoring and
- whether you require medical counselling in relation to the work that triggered the requirement for health monitoring.

We respect your privacy and treat the management of your personal and health information very seriously. We are bound to manage your personal and health information in accordance with the Privacy and Personal Information Protection Act 1998 (NSW) and the Health Records and Information Privacy Act 2002 (NSW). We apply these legal obligations when collecting, storing, using and disclosing your personal and health information.

If you ask us, we will tell you what personal and health information about you we have, and give you access to it. We will allow you to update, correct or amend your personal or health information in certain circumstances, for instance if it is inaccurate.

Consent

I confirm that I have read and understood the information provided above and provide my consent for icare Dust Diseases Care to collect, access, use and/or disclose my personal and health information accordingly.

Signature

Date (DD/MM/YYYY)