

## Asbestos Health Surveillance Report

<b>PART ONE</b>			
Worker Details			
<b>Surname</b>		<b>First Name</b>	
<b>Contact Number</b>		<b>Gender</b>	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
<b>Date of Birth</b>			

<b>PART TWO</b>			
Employer Details			
<b>Business Name</b>			
<b>Contact Surname</b>		<b>First Name</b>	
<b>Phone</b>		<b>Email</b>	

<b>PART THREE</b>	
The Role	
<b>Role</b>	Technician
<b>Length of time the worker has been carrying out the role</b>	3 Years

<b>PART FOUR</b>	
Health Monitoring	
<b>Date of health monitoring</b>	

<b>PART FIVE</b>	
Recommendation	
I certify that I have reviewed the health assessment <input checked="" type="checkbox"/> biological monitoring <input type="checkbox"/> for the person whose name appears above in Part One and that in my opinion this worker:	
<input checked="" type="checkbox"/>	Is fit for asbestos risk work
<input type="checkbox"/>	Has received medical counseling in relation to work practices and is fit to continue asbestos risk work
<input type="checkbox"/>	Must be removed from asbestos risk work
<input type="checkbox"/>	Is fit to resume asbestos risk work
<input type="checkbox"/>	Shows symptoms or signs of having contracted a disease, injury or illness as a result of carrying out asbestos risk work
<input type="checkbox"/>	Is not fit for asbestos risk work on medical grounds
<input type="checkbox"/>	Shows symptoms or signs of having contracted a disease, injury or illness not related to asbestos exposure and should consult their General Practitioner
I recommend that the person conducting the business or undertaking	
<input type="checkbox"/>	Immediately remove the worker from asbestos risk work
<input type="checkbox"/>	Review work practices and take remedial measures to reduce the worker's exposure to asbestos
<input checked="" type="checkbox"/>	Repeat medical examination for the worker on <b>17/3/2019 if performing licensed asbestos removal work, otherwise as per a risk assessment considering the degree of past and expected future asbestos exposure (default recommendation is two years), or at termination of asbestos-risk work.</b>
<b>Other recommendations</b>	Facial hair noted at assessment - ensure clean-shaven if a mask seal is required.

<b>PART Six</b>	
Doctor Details	
<b>Registered Medical Practitioner Details</b>	<b>Signature</b>
	<b>Date</b>

Name:	
Date:	

**PART ONE** Photo ID Sighted:  Yes  No

Section 1: Your personal details			
Surname		First Name	
Address		Postcode	
Suburb / State		Email Address	
Home Phone		Mobile Phone	
Date of Birth		Gender	<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female
Family Doctor		Family Doctor Phone	
Employer		Site Name	
Job Role		Contact Person	
Length of Employment		Contact Phone	
Employer Address			

Section 2: Your employment history (Please give details of current and previous work positions)			
Company	No. of Years	Job Title	Chemical Exposure
1.	3	Tech	
2.			
3.			
4.			

Section 3: Your health history					
	Yes	No		Yes	No
Q1. Have you been / are you currently being treated for any medical condition?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Q4. Have you ever been exposed to toxic substances or environmental hazards?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Q2. Do you expect to consult a doctor or expect to receive any treatment in the near future?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Q5. Have you had trouble wearing (PPE) personal protective equipment, safety equipment or breathing apparatus?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Q3. Have you been admitted to hospital?	<input type="checkbox"/>	<input checked="" type="checkbox"/>			
If you answered 'Yes' to any of the above please provide details:					
Dr to provide comments for any 'Yes' responses: (reference Q No.)					

Section 4: Medical History – Are you or have you ever received treatment or medical advice for any of the following?								
	Yes	No		Yes	No		Yes	No
Q6. Lung / Breathing problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Q8. Breathing problems, nasal blockage, nose bleeds or lump in nose	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Q9. Skin disorders / Dermatitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Q7. Asthma / Hay fever / Allergies	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
If you answered 'Yes' to any of the above please provide details:								
Dr to provide comments for any 'Yes' responses: (reference Q No.)								

**Section 5: Respiratory Questionnaire**

		Yes	No	Details
<b>Cough and Phlegm</b>				
Q10.	Do you usually cough first thing in the morning?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Mild morning cough - - sneeze cough
Q11.	Do you usually cough during the day or at night?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>If 'No' go to Q18</b>				
Q12.	Do you cough like this on most days for as much as 3 months of the year	<input type="checkbox"/>	<input type="checkbox"/>	
Q13.	Do you usually bring up phlegm from your chest first thing in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	
Q14.	Do you usually bring up phlegm from your chest at any other time of the day or night?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>If 'No' go to Q18</b>				
Q15.	Do you bring up phlegm like this on most days for as much as three months each year?	<input type="checkbox"/>	<input type="checkbox"/>	
Q16.	In the past three years have you had a period of increased cough and phlegm lasting for three weeks or more?	<input type="checkbox"/>	<input type="checkbox"/>	
Q17.	If Yes, have you had more than one such period	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Breathlessness</b>				
Q18.	Do you get short of breath when hurrying on level ground or walking up a slight hill?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>If 'No' go to Q22</b>				
Q19.	Do you get short of breath walking with other people of your own age on level ground?	<input type="checkbox"/>	<input type="checkbox"/>	
Q20.	Do you have to stop for breath when walking at your own pace on level ground?	<input type="checkbox"/>	<input type="checkbox"/>	
Q21.	Have you at any time in the last 12 months been woken at night by an attack of shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Wheezing and Chest Tightness</b>				
Q22.	Have you had attacks of wheezing or whistling in your chest at any time in the last 12 months?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Q23.	Have you ever had attacks of shortness of breath with wheezing?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Q24.	If 'Yes', was your breathing absolutely normal between attacks?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>Smoking</b>				
Q25.	Do you or did you smoke more than 1 cigarette/day; a cigar/week; 2oz pipe tobacco/month?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>If 'No' proceed to social history questions</b>				
Q26.	Do (did) you inhale smoke?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	If Yes circle slightly moderately deeply
Q27.	How old were you when you started smoking regularly?		<input checked="" type="checkbox"/>	
Q28.	Do (did) you smoke manufactured cigarettes?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
<b>if 'No' go to Q33</b>				
Q29.	How much do (did) you smoke per day on weekdays? (number of cigarettes)			100 (7 cig/day) - smoke 5-6 cigs/day
Q30.	How many per day on weekends?			40 (20 cigs/day)
Q31.	Do (did) you smoke plain or filtered cigarettes?			winfield Blue
Q32.	What brands do (did) you usually smoke?			stubs
Q33.	Do (did) you smoke hand rolled cigarettes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	smokej
<b>If 'No' go to Q36</b>				
Q34.	How much tobacco do (did) you usually smoke per week in this way?			25 1750
Q35.	Do (did) you put filters in these cigarettes?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	



**Section 8: Workplace Hygiene**

	Yes	No	Details
Q56. Do you usually wash your hands before eating, drinking or smoking?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Q57. Are clothes washed separately at work in a dedicated washing machine?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Q58. Are asbestos fibres vacuumed from work clothes with an asbestos cleaner with a HEPA filter and footwear wiped?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Q59. Do you remove your protective garments prior to leaving the asbestos work area?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Then my of garments
Q60. Do you change into clean clothing when you have left the asbestos work area?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Q61. Do you shower following completion of the asbestos work?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

**Doctors Comments**

\_\_\_\_\_

**Section 9: Declaration**

Please read the following and sign where indicated

**Declaration** - I declare that I have answered the above correctly and completely, to the best of my knowledge

**Statement authorisation** - I give my consent for the results of my asbestos medical examination to be given to my employer. I understand that my employer is obliged to keep my results in a secure and confidential manner. I also give my consent for the release of information contained in the health surveillance assessment to my treating or family doctor.

Did you receive any assistance by another person to complete this form?  Yes  No

Did you receive any assistance by another person to complete this form?  Yes  No

If Yes: provide details

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Please return this form to reception when completed

EXAMPLED DOCUMENT ONLY



**PART TWO** Doctor to complete

**Section 10: Measurements**

1. Height	170 cm	2. Weight	59.5 kg	3. BMI	
4. Blood Pressure	1 <sup>st</sup> reading: 127/72	73 Bpm	2 <sup>nd</sup> reading:		
Comments:					

**Section 11: Respiratory**

5. Breathing normal and regular in character?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	8. Signs of past/present respiratory disease absent?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Auscultation normal?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	9. Spirometry normal?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
7. Spirometry (only if requested)		<input type="checkbox"/> Report attached	

	Actual	Normal	
FEV1	430 L/min	98	%
FVC	477 L/min	94	%
FEV1 / FVC	90		%

Comments: *chest clear*  
*near 45% on next.*

**Section 12: Respirator Fit**

10. Facial hair?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Dental deformities?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
11. Deformity of face?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Yes <input type="checkbox"/> No <input type="checkbox"/>
Comments:			

## Other comments on Part 1 and/or Part 2:

Question No.	Comments:
	<i>— chest - has a band - Operated about          20k of heavy metal over head,          not a tight fit.</i>
	<i>— Ask to shave.</i>

**Checklist: The following assessments have been completed:**

	Satisfactory	Other	N/A		Satisfactory	Other	N/A
Medical history	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical examination	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

I have provided education to the patient regarding potential health effects of asbestos and have discussed any abnormalities detected in the medical assessment with the patient.

 Doctor  
 Stamp

C



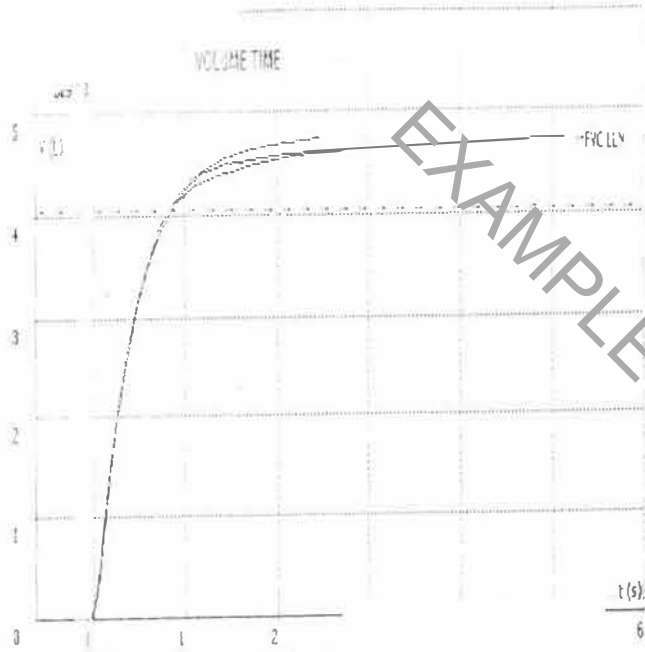
HEIGHT : 170 CM      AGE : 21 YRS  
 SMOKER : SMOKER      SEX : MALE  
 NORMAL VALUES : Gcre

TEST DATE :      TEST TIME : 08:40  
 No ATTEMPTS : 3      VALUES AT BTPS  
 FVC WITHIN : 0.01 L      FEV1 WITHIN : 0.03 ATS  
 TEST QUALITY: GRADE A

SERIAL # :      CALIBRATION : 01/DEC/2016

Index		Norm Pred	Best 1	Best 2	Best 3	Meas BEST	%Pred
FVC	L	5.06	4.77	4.76	4.74	4.77	94
FEV1	L	3.33	4.30	4.27	4.23	4.30	98
FEV1F		0.86	0.90	0.90	0.89	0.90	105
FEV6	L	5.06	-	4.76	4.74	4.76	94
PEF	L/min	615	494	548	543	548	89
FEF 25-75L/s		4.70	5.03	5.06	4.83	5.03	107
FEF25	L/s	8.09	7.97	8.14	8.63	7.97	99
FEF50	L/s	5.32	5.82	5.90	5.46	5.82	109
FEF75	L/s	2.45	2.85	2.81	2.71	2.85	116

\* BELOW LOWER LIMIT OF NORMALITY (LLN)



SUGGESTED INTERPRET  
 Normal ventilatory function.

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