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

**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. EMPLOYMENT IN WORK WITH ISOCYANATES** **(X) all relevant boxes** | |
| New isocyanates work  Not directly working with isocyanates | |
| Current employee continuing in such work  Worked in isocyanates since:       (mm/yyyy)  With current employer since:       (mm/yyyy) | |
| Name of previous workplace / company (if applicable) and when      /      (yyyy/yyyy) | |
| **Isocyanates history**  Automotive smash repairs / Motor body builders  Other use of 2-pack paints or coatings  Boat body & repairers  Manufacture / Supply of 2-pack paints/coating  Floor sanding / sealing  Processes involving heating of polyurethane products  Polyurethane foam manufacture  Other (please specify):  Spray painting workshop | |
| **5. PERSONAL CONTROLS** **(X) all relevant boxes** | |
| Clean shaven:  Yes  No | Clean hands with thinner:  Yes  No |
| Shower and change into clean clothes at end of shift:  Yes  No | |
| Trained in isocyanates processes and procedures:  Yes  No | |
| **6. WORKPLACE CONTROLS** | |
| Wear gloves:  Yes  No | Mechanically ventilated mixing /  Yes  No  curing area |
| Eye protection:  Yes  No | Spray booth:  Yes  No |
| Air line respirator:  Yes  No | Air quality tested  Yes  No  (for air line respirators): |
| Other respirator (specify type): | Local exhaust ventilation:  Yes  No |
| **7. QUESTIONAIRE – RESPIRATORY & SENSITISATION (X) all relevant boxes** | |
| 1. Current smoker:  Ex smoker:  Never smoked:   Aged started       years Stopped       years Amount       per day   1. Any asthma?  Yes  No  only in childhood   Any skin rash, eczema or dermatitis?  Yes  No  only in childhood  Frequent itchy eyes / skin, watery eyes, runny / blocked nose?  Yes  No  Any wheeze, chest tightness or shortness of breath?  Yes  No  If **Yes**, are you better on weekends or when on holidays?  Yes  No   1. If **Yes** to any of the above give brief description: | |

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| **8. LUNG FUNCTION TESTS**  **Registered medical practitioner to complete and (X) all relevant boxes**  **Attach spirometry printouts, graphs, report.** | | | | | | | | |
| 1. **SPIROMETRY** 2. **Attach printouts with 3 valid tests (which meet ATS “satisfactory blow” criteria) and the corresponding flow-volume graphs.** 3. **If submitting pre and post-bronchodilator spirometry, please clearly mark the print-outs.** 4. **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) | | | | | | | | |
| 1. **LABORATORY LUNG FUNCTION TEST (including DLCO)**   Attach report  **Comments:** | | | | | | | | |
| **9. DISCRETIONARY TESTING: BIOLOGICAL MONITORING RESULTS (Urine Isocyanate Levels)** | | | | | | | | |
|  | **Date** | | | **Results** | | | **Recommended Action and/or Comment** | |
| 1. | /     / | | |  | | |  | |
| 2. | /     / | | |  | | |  | |
| 3. | /     / | | |  | | |  | |
| 4. | /     / | | |  | | |  | |
| **10. RESPIRATORY ASSESSMENT (taking into account all of the above)** | | | | | | | | |
| Satisfactory  Abnormal (please describe)  Comment: | | | | | | | | |
| **11. DERMATOLOGICAL ASSESSMENT (X) all relevant boxes** | | | | | | | | |
| Satisfactory  Abnormal (please describe)  Comment: | | | | | | | | |

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| **12. RISK ASSESSMENT – Registered medical practitioner to complete (X) all relevant boxes** | | |
| 1. New to isocyanate work 2. New employee but with previous exposure to isocyanates 3. Current employee continuing in isocyanates 4. Satisfactory personal hygiene  Yes  No 5. Satisfactory workplace controls  Yes  No 6. Clinical picture indicative of adverse health effects from isocyanate exposure   Yes  No  Maybe  Comment: | | |
| **13. RECOMMENDATIONS – Registered medical practitioner to complete (X) all relevant boxes** | | |
| 1. Fit for work with isocyanates **Next review date:** 2. Unfit for work with isocyanates 3. Actions and recommendations   Review / repeat lung function test in       months / weeks  Counselled employee  Informed employee to review and implement controls in workplace  Remove from exposure to isocyanates  Referral to medical specialist        Appointment date:  Occupational Physician  Respiratory Physician  Physician (specify)  Comment: | | |
| **Registered Medical Practitioner – responsible for supervising health monitoring** | | |
| 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