|  |  |
| --- | --- |
| **WorkSafe Health Monitoring Form**  **Notification: LEAD** |  |

**CONFIDENTIAL  MINING  GENERAL**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. EMPLOYER DETAILS (Principal) | | | | | | | |
| 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 | | | | | | | |
| Job: | | | | Country of birth: | | | |
| Address: |  | | | | | | |
| Mobile: | | | | Email: | | | |
| Female of reproductive capacity:  Yes  No Breastfeeding:  Yes  No | | | | | | | |
| GP Name:       Tel:  Medical Practice Name:  Address :  Email: | | | | | | | |
| Working in mining or at a mining site  Yes  No | | | | | | | |
| If yes, name of mine site: | | | | | | Name of mining company: | |
| 4. EMPLOYMENT IN LEAD-RISK WORK (X) all relevant boxes | | | | | | | |
| *New to lead work*  Yes No *Not directly working with lead*  *Worked with lead since       (mm/yyyy) With current employer since       (mm/yyyy)* | | | | | | | |
| *Lead-risk Work* ***(✓) all relevant boxes*** | | | | | | | |
| Fire Assay  Foundry  Lead battery - maintenance  Lead burning  Lead flux - manufacture | | Leadlight work  Lead paint – manufacture  Lead paint - painting  Lead paint - stripping/cleaning  Lead sinker - manufacture | | | | | Metal Recycling  Monumental work  Radiator Repair  Shooting gallery  Other (specify) : |
| 5. PERSONAL HYGIENE (X) all relevant boxes | | | | | | | |
| Smoker  Ex- Smoker  Non-Smoker | | | | Clean shaven Yes No | | | |
| Shower & change into clean clothes at end of shift  Yes  No | | | | | | | |
| Hazardous substances training (including health effects)  **Yes  No** | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 6. WORKPLACE CONTROLS (X) all relevant boxes | | | | |
| Wear gloves  Yes  No | | | Laundering by employer  Yes  No | |
| Local exhaust ventilation  Yes  No | | | Smoking / eating/ drinking in workshop  Yes  No | |
| Overalls/ Work Clothing  Yes  No | | | Dry Sweeping  Yes  No | |
| Wash basin / shower (hot/cold)  Yes  No | | | Compressed air to clean equipment  Yes  No | |
| Comments: | | | | |
| 7. BIOLOGICAL MONITORING RESULTS (Registered medical practitioner to complete)Include previous two test results (if available) and attach copy of pathology laboratory results | | | | |
|  | Date | Blood Lead Level (μg/dL) | |  |
| 1. | /     / |  | | Insert baseline or last known result in (1) and date |
| 2. | /     / |  | | Office use only: WISE ID:  TEST NO: |
| 3. | /     / |  | |
| 8. RISK ASSESSMENT (Registered medical practitioner to complete) Indicate (X) | | | | |
| 1. New to lead work.  1. New employee but with previous exposure to lead.  1. Current employee continuing in lead work. 2. Satisfactory personal hygiene   Yes   No 3. Satisfactory workplace controls   Yes   No 4. Clinical picture indicative of adverse health effects from lead   Yes  No  Maybe | | | | |
| Comments: | | | | |
| 9. RECOMMENDATIONS (Registered medical practitioner to complete) Indicate (X) | | | | |
| 1. Suitable to work with lead   Review / Repeat blood lead level in            months/ weeks.   1. Remove from lead work   Counselled employee  Informed employer to review and implement controls in workplace.  Medical examination within 7 days on  Review / Repeat test in            months/ weeks.  Referral to medical specialist                 Appointment date  Occupational Physician  Physician (specify)  3.  Suitable to resume lead work after removal  **Next review date:** | | | | |
| Comments: | | | | |

|  |  |  |
| --- | --- | --- |
| **10. Registered Medical Practioner (responsible for supervising health monitoring)** | | |
| Name: | Signature: | Date:      /     / |
| Tel: | Fax: | Contact Person: |
| Medical Practice Address: | | |
| Email: | | |
| AHPRA registration number: | | |
| **Instructions for submissions 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 the WorkSafe Occupational Physician or Occupational Health Nurse, call 1300 307 877

A41114564