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| **WorkSafe Health Monitoring Form**  **Notification: SILICA (Respirable crystalline dust)** |  |

**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: | |  | Tel: |
| 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 at a mining site  Yes  No | | | |
| If yes, name of mine site | | Name of mining company | |
| 4. INDUSTRY (X) all relevant boxes | | | |
| Abrasive blasting  Uncontrolled dry cutting of concrete  Uncontrolled dry surfacing/polishing of concrete or aggregate  Controlled concrete cutting or polishing (wet or on tool extraction)  Concrete spraying (shotcrete)  Tunnelling  Foundry casting | | Stone fabrication & installation  Natural stone  Artificial stone  Stonemasonry – other (specify):  Manufacturing lead flux  Assay laboratory sample preparation  Mining  Other industry (specify): | |

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| 5. EXPOSURE TO SILICA DUST (X) all relevant boxes | | | | | |
| New to silica work  Continuing in silica work  Not directly working with silica  Year of 1st exposure to silica dust       (mm/yyyy) Total years of exposure | | | | | |
| Previous employer | Dates yyyy to yyyy | Job / Role | | Work activities / tasks | Years exposed |
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| 6. WORKPLACE CONTROLS (X) all relevant boxes | | | | | |
| **Respiratory Protective Equipment (RPE) provided by Employer** YesNo  **Use of respiratory protection:**  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 | | | **Workplace provision**  Hearing protection  Yes  No  Eye protection  Yes  No  Protective work clothing  Yes  No  Wash basins & showers provided  Yes  No  (hot and cold water)  Meals room separate from workshop  Yes  No | | |
| Training in RPE - fit check, use, storage & maintenance  Yes  No  Training in hazards of silica, risks to health, and safe work practice  Yes  No | | | | | |
| **Dust Control Measures**  Power tools with dust extraction  Yes  No  Wet work (Dust suppression with water for cutting, grinding, polishing)  Yes  No  Automated machine wet cutting/polishing (CNC)  Yes  No  Floor is HEPA vacuumed or wet mopped  Yes  No  Wash down work area at end of shift  Yes  No  Recycled water and silica waste capture system  Yes  No | | | | | |
| **Comments:** | | | | | |

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| **7. SILICA WORK EXPOSURE QUESTIONNAIRE – Registered Medical Practitioner to complete (X) all relevant boxes** | | | | | | |
| **7(a) CURRENT JOB** | | | | | | |
| 1. **Can you describe your typical work activities and work environment?**   (include how dusty, dry or wet work, any respiratory protection, duration etc)  **Comments:** | | | | | | |
| 1. **Can you estimate how often you perform dry work using hand held power tools?**   (e.g. power tool cutting, grinding, polishing, /drilling, machining)  All the time  Mostly (3/4 time)  Often (1/2 time)  Sometimes (1/4 time)  Never / rarely  **Comments:** | | | | | | |
| **7(b) PAST SILICA WORK / EMPLOYMENT – Registered Medical Practitioner to complete** | | | | | | |
| 1. **Can you describe your typical work activities and work environment?**   (include how dusty, dry or wet work, any respiratory protection, duration, etc) | | | | | | |
| **2. Can you estimate how often you perform dry work using hand held power tools?** (e.g. power tool cutting, grinding, polishing, drilling, machining)  All the time  Mostly (3/4 time)  Often (1/2 time)  Sometimes (1/4 time)  Never / rarely  **Comments**: | | | | | | |
| **7(c) OTHER HAZARDOUS SUBSTANCE EXPOSURE – Registered Medical Practitioner to complete**  **(X) all relevant boxes** | | | | | | |
| 1. **In your current workplace, do you work with any other hazardous substances? If Yes, (X) below**:   Asbestos  Lead  Isocyanates  Chromium  Other (specify)   1. **Have you in your past ever worked with other hazardous substances? If Yes, (X) below:**   Asbestos  Lead  Isocyanates  Chromium  Other (specify)  If yes, please describe: | | | | | | |
| **7(d) Total exposure to dry cutting etc with power tools       months       years**  **Comments:** | | | | | | |
| 8(a) MEDICAL & RESPIRATORY QUESTIONNAIRE – Registered Medical Practitioner to complete(X) all relevant boxes | | | | | | |
| **1.** Smoking history [DMIRS office use. Pack years = ]  Never smoked  Current smoker Age started       Amount       per day  Ex-smoker Age started       Age stopped       Amount       per day       Years smoked  **2.** a) Have you ever had asthma?  Yes  No  Only in childhood  b) Have you ever had COPD, bronchitis or emphysema? {circle}  Yes  No  c) Have you ever had any other lung problems?  Yes  No  d) Have you ever had any heart problems?  Yes  No  e) Have you ever had arthritis/ painful or swollen joints? {circle}  Yes  No  f) Have you ever autoimmune conditions e.g. Rheumatoid or SLE?  Yes  No  g) Have you ever had tuberculosis (TB)?  Yes  No  **3.** a) Any nasal congestion/ blocked nose? {circle}  Yes  No  b) Any wheeze, chest tightness or shortness of breath? {circle}  Yes  No  If Yes, are you better on weekends or when on holidays?  Yes  No | | | | | | |
| **4**. a) Do you usually cough first thing in the morning?  Yes  No  b) Do you usually cough during the day – or night?  Yes  No  If Yes to a) or b)  c) Do you cough like this on most days for as much as 3 months each year?  Yes  No  **5**. a) Do you usually bring up phlegm first thing in the morning?  Yes  No  b) Do you usually bring up phlegm during the day – or night?  Yes  No  If Yes to a) or b)  c) Do you bring up phlegm like this on most days for as much as 3 months each year?  Yes  No  **6.** a) Are you troubled by shortness of breath when hurrying on level ground or walking up a  Yes  No  slight hill?  b) Do you get short of breath walking with other people of your own age on level ground?  Yes  No  c) Do you have to stop for breath when walking at your own pace on level ground?  Yes  No  d) How far can you walk before you have to stop for breath? Metres  **7.** If Yes to any above, describe (symptoms, treatment, status): | | | | | | |
| **8**. If any other relevant health problems impacting on your health and your lungs and heart, provide details.    **9**. List any medications you currently take: | | | | | | |
| Worker is asymptomatic  Worker has respiratory symptoms | | | **Comments:** | | | |
| 8(b) MEDICAL EXAMINATION – Registered Medical Practitioner to complete (emphasis on respiratory and cardiac system, joints) | | | | | | |
| Height:       cm | | Weight:       kg | | BMI: | | |
| Pulse:       /min | | BP:       mm/Hg | | Respiratory Rate:       /min | | |
| Breath sounds: | | | | | | |
| **Relevant findings**: | | | | | | |
| **Comments**: | | | | | | |
| **9. IMAGING – Registered Medical Practitioner to complete (if required based on risk) (X) all relevant boxes**  **Attach Imaging Reports: bs00481_** | | | | | | |
| **Date of previous LDCT:**  **Low Dose CT scan**  Attach report by radiologist with appropriate commentary (modified ILO (Kusaka) classification)  Normal  If not normal, comment: | | | | | | |
| **10. LUNG FUNCTION TESTS – Registered Medical Practitioner to complete (X) all relevant boxes**  **Attach spirometry printouts, graphs, report: bs00481_** | | | | | | |
| 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:** | | | | | | |
| 11. ASSESSMENT (taking into account all of above – Registered Medical Practitioner to complete) **(X) all relevant boxes** | | | | | | |
| 1. Worker’s personal hygiene is  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:** | | | | | | |
| **12. RECOMMENDATIONS – Registered Medical Practitioner to complete (X) all relevant boxes** | | | | | | |
| 1. Suitable for work with silica with effective safety controls including respiratory protection & dust suppression 2. Uncertain of suitability for work with silica 3. Remove from silica work 4. More tests: 5. Referral to Respiratory Physician\*\* for assessment and clinical advice   Respiratory Physician (name)   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 monitoring  Inform Employer to review and implement controls in workplace   1. Next review date   Repeat spirometry / lung function test in  Repeat LDCT in | | | | | | |
| **Comments:**  NB: *\** *Registered Medical Practitioner to notify WorkSafe promptly - call 1300 307 877*  *\*\* Registered Medical Practitioner to forward Respiratory Physician report to WorkSafe Occupational Physician promptly* | | | | | | |
| **13. REGISTERED MEDICAL PRACTITIONER DETAILS** | | | | | | |
| Name: | | Signature: | | | | Date:      /     / |
| Medical Practice Address: | | | | | | |
| Tel: | | Contact Person: | | | | |
| Email: | | | | | | |
| AHPRA registration number: | | | | | | |
| **Instructions for submission to DMIRS** | | | | | | |
| Check that all sections of the form have been completed  Attach relevant reports (spirometry, pathology, radiology, medical specialist)  Incomplete submissions will be returned  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