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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 silicaYear 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 [ ]** Yes **[ ]** No**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 [ ]  NoEye protection [ ]  Yes [ ]  NoProtective work clothing [ ]  Yes [ ]  NoWash 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 [ ]  NoTraining in hazards of silica, risks to health, and safe work practice [ ]  Yes [ ]  No |
| **Dust Control Measures**Power tools with dust extraction [ ]  Yes [ ]  NoWet work (Dust suppression with water for cutting, grinding, polishing) [ ]  Yes [ ]  NoAutomated machine wet cutting/polishing (CNC) [ ]  Yes [ ]  NoFloor is HEPA vacuumed or wet mopped [ ]  Yes [ ]  NoWash down work area at end of shift [ ]  Yes [ ]  NoRecycled 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 [ ]  NoIf 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 [ ]  NoIf 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 completedAttach relevant reports (spirometry, pathology, radiology, medical specialist)Incomplete submissions will be returnedSubmit via:Email to safety@dmirs.wa.gov.au orSend 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