Feasibility of Occupational Health Data in the EHR: A Clinician’s Perspective

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- Assistant Professor: Stony Brook University – School of Medicine
- LIOEHC: Member of the NYS Occupational Health Clinic Network
Discussion Topics- Occupational Health Information and the EHR

- Why and How Occup. Health Info Included in EHR
- Types of occupational health data collected
- Planned Uses
- Case Studies to Illustrate Benefits and Use
  - LBP, Asthma, Lead toxicity
- Challenges & Recommendations
Why: Occupational Health Information Within the EHR Enables Meaningful Use

- Improve quality, safety, and efficiency of care
  - Accurate dx, mgmt, tx depends upon recognition of occupational health association and elimination of cause.

- Engage patients and their families
  - Expand to Include Patient Reps- employers, attorneys

- Improve care coordination among stakeholders
  - Coordinate care among HCW, employer, patients, patients’ reps - ensure return to work, treatment approval, prevention, RTW, SSD determination
Why: Occupational Health Information Enables Meaningful Use

- Improve population and public health
  - Causation attribution enables
    - Billing to responsible agency eg workers comp,
    - Prevention strategies- individual accommodation, PPE, and population surveillance
    - Savings to health care system, employers, economy

- Ensure privacy and security protections
  - Differentiation between work and non work related problems and differential access

- Continuous Learning
Why: Meet Needs of Stakeholders-
NYS DOH & NYS Occupational Health Clinic Network

- Occupational Health Clinic Network Requires Compliance with Practice Clinical Guidelines- QA/QI
  - *Asbestos-related, asthma, upper extremity disorders, carpal tunnel syndrome, low back disorders, lead poisoning, noise-induced hearing loss, and solvent-related disorders, Respirator clearance examinations

- OHNIS- Occupational Health Information Systems Database required by DOH
  - Patient Demographics, Diagnoses, Patient Exposures, Industries, Occupations, Referral Patterns

- OSHA Mandated Exposures require surveillance
  - Facilitated with EHR reminders
Why: Meet Needs of Stakeholders - Patients, Reps, Employers, NYS WCB, SBUMC

- **Patients/Reps**: medical care, prevention, education, SSD evaluation
- **Attorneys**: legal documentation,
- **Employers/Ins. reps**: medical records, guideline compliance, return to work (RTW)
- **NYS WCB**: medical tx guidelines
- **SBUMC**: registration, payment, HER requirements
- **Shared System Needs**: detailed, accurate, easily accessed, comprehensive information on occupational health conditions, risk factors, services provided, outcomes
How: Include Key Occupational Health Information into Primary Care EHR:

- Requires multi-faceted approach ideally or select options
- I. Key questions included in Chief complaint, and Occupational History
- II. Sentinel symptoms or conditions trigger inclusion of occupational medicine questions
  - Modules for supplemental occupational medicine questions and information
- III. Modules for occupational health information needed by all providers
  - Workers compensation data
  - Return to work
Key Occupational Health Questions for Primary Care EMR & Location:  Option 1

- Five Key Questions and Locations in EHR
  - Job title and function-Demographics
    - 1. What type of work do you do? (occupation =SOC code)
    - 2. What are your essential and most hazardous job functions?
      - Description from O*Net

- Exposure categories- Social/Occupational Hx
  - 3. Are you now or have you previously been exposed to dusts, fumes, chemicals, metals, radiation, loud noise, cumulative trauma or other hazards?

- Temporal Relationship- Review of Systems
  - 4. Are your symptoms better, worse or unchanged at work?
  - 5. Do you think your health problems are related to your work?“
Key Occupational Health Information- Sources of Data:  Option 1

• I. Five Key Questions

• Job title and function-
  • 1. Current occupation essential and most hazardous job functions?
  • Location in HER: Demographics, patient, employer profile.
  • Source: O*Net- uses SOC code for the occupation code and
  • Source: NAICS for industry code (previously SIC codes)

• Exposure categories-. Dusts, fumes, chemicals, metals, radiation, loud noise, heavy or repeated physical work eg lifting or other hazards?
  • Location in HER: Social and Occupational Hx
  • Source: AOEC Exposure Database

• Temporal Relationship- Review of Systems
  • 4. Are your symptoms better, worse or unchanged at work?
  • 5. Do you think your health problems are related to your work?“
  • Location in HER: History of Present Illness
EHR: Option 2- Include Templates of Occupational Health Questions for Sentinel Conditions and Exposures

- **Sentinel Health Conditions**
  - Pulmonary Fibrosis
  - Asthma
  - Tuberculosis
  - Carpal Tunnel Syndrome
  - Lung Cancer
  - Mesothelioma
  - Leukemia
  - Sensorineural hearing loss
  - Contact Dermatitis
  - Asbestosis

- **Sentinel Exposures** – eg OSHA Mandated Agents
  - Asbestos
  - Noise
  - Lead
  - Hazardous Waste Exposure
  - Bloodborne Pathogens
  - Formaldehyde
  - Cadmium
  - Benzene
  - Ethylene oxide
  - Cotton Dust
Some Sources of Occupational Templates to Guide Management and Treatment

- LIOEHC Developed Templates Based Upon
  - NYS WCB Medical Treatment Guidelines
  - ACOEM Guidelines
  - NYS Occupational Health Clinic Network Practice Guidelines for Occupational Disease*
- Military eg Navy Templates

Steps in Development of LIOEHC - E*Healthline-EHR

- Created patient and/or employer screens and portals to obtain
  - Industry code, from NAICS dropdown
  - Import Job title (SOC code) and job description from o*net

- Patient encounter
  - Patient questionnaire includes 5 key questions; reviewed by Health care provider (HCP)
  - Entry of sentinel diagnosis or exposure triggers key questions for HCP review with patient based upon guidelines
  - Questions address
  - Educational reminders occur

- Forms needed for patient - can be auto populated
  - Workers compensation, Return to work, Disability Assessment
## Occupational and Environmental Medical History

### LIOEHC
The Long Island Occupational and Environmental Health Center

<table>
<thead>
<tr>
<th>Name</th>
<th>SS#</th>
<th>Job Title</th>
<th>Years with Employer</th>
<th>DOB Age</th>
<th>Personal Physician</th>
<th>Rest Phone</th>
<th>Date of Exam</th>
</tr>
</thead>
</table>

### 1. REVIEW OF SYMPTOMS:

#### Check if you have any of the following symptoms in the last 3 months:

- **Bleeding/Easy Bruising**
- **Cough**
- **Dental problems**
- **Dizziness**
- **Drained nose**
- **Eye pain/watery eyes**
- **Fatigue**
- **Hair loss**
- **Headache(s)**
- **Joint pain**
- **Muscle pain**
- **Numbness, tingling**
- **Pneumonia**
- **Short of breath w/exercise**

#### General:

- Head/Eyes/Ears/Nose/Throat:
- Skin:
- Blood in urine:
- Breathless:
- Chest tightness, pain:
- Diarrhea:
- Edema:
- Headache:
- Heart:
- Kidney or bladder pain:
- Nausea:
- Oral:
- Pain:
- Sore throat:
- Swelling:
- Vision:
- Weight gain or loss:
- Yellow:

### 2. PAST MEDICAL HISTORY:

#### Allergies:

- Dust:
- Hay fever:
- Latex:
- Penicillin:
- Pesticides:
- Pollen:
- Bladder and kidneys:
- Skin:
- Sexual:
- Anemia:
- Blood disorder:
- Cancer:
- Cardiovascular:
- Circulatory:
- High blood pressure:
- Heart:
- High cholesterol:

#### Emotional Problems:

- Anxiety/nervousness:
- Depression:
- Fatigue:
- Headache:
- Memory loss:
- Hearing loss:
- Stress:
- Sleep problems:
- Skin:
- Gastritis/Intestines:
- Pulmonary (Lungs):
- Sexual:
- Reproductive (Males):
- Reproductive (Females):
- Abnormal pregnancy:
- Abdominal pain:
- Back pain:
- Breast lump:
- Cataracts:
- Cold:
- Congestion:
- Cold:
- Fatigue:
- Fever:
- Headache:
- Insomnia:
- Ivory:
- Knee pain:
- Neck pain:
- Pain:
- Polio:
- Raynaud's:
- Renal:

#### Surgery:

- Cancer surgery:
- Carpal tunnel:
- Dental:
- Endocrine:
- Gastrointestinal:
- Heart:
- Head:
- Knee:
- Hip:
- Spine:

#### Acrea:

- Acrea:
- Acne:
- Arthritis:
- Back pain:
- Breast pain:
- Cataracts:
- Cold:
- Congestion:
- Cold:
- Fatigue:
- Fever:
- Headache:
- Insomnia:
- Ivory:
- Knee pain:
- Neck pain:
- Pain:
- Polio:
- Raynaud's:
- Renal:

#### Tumors:

- Cancer:
- Carcinoma:
- Cataracts:
- Cold:
- Congestion:
- Cold:
- Fatigue:
- Fever:
- Headache:
- Insomnia:
- Ivory:
- Knee pain:
- Neck pain:
- Pain:
- Polio:
- Raynaud's:
- Renal:

#### Heart:

- Cancer:
- Carcinoma:
- Cataracts:
- Cold:
- Congestion:
- Cold:
- Fatigue:
- Fever:
- Headache:
- Insomnia:
- Ivory:
- Knee pain:
- Neck pain:
- Pain:
- Polio:
- Raynaud's:
- Renal:

#### Head:

- Cancer:
- Carcinoma:
- Cataracts:
- Cold:
- Congestion:
- Cold:
- Fatigue:
- Fever:
- Headache:
- Insomnia:
- Ivory:
- Knee pain:
- Neck pain:
- Pain:
- Polio:
- Raynaud's:
- Renal:

#### Knee:

- Cancer:
- Carcinoma:
- Cataracts:
- Cold:
- Congestion:
- Cold:
- Fatigue:
- Fever:
- Headache:
- Insomnia:
- Ivory:
- Knee pain:
- Neck pain:
- Pain:
- Polio:
- Raynaud's:
- Renal:

#### Renal:

- Cancer:
- Carcinoma:
- Cataracts:
- Cold:
- Congestion:
- Cold:
- Fatigue:
- Fever:
- Headache:
- Insomnia:
- Ivory:
- Knee pain:
- Neck pain:
- Pain:
- Polio:
- Raynaud's:
- Renal:

### Explain any positive answers:
**Patient Health Questionnaire/Portal**

3. IMMUNIZATION HISTORY

<table>
<thead>
<tr>
<th>Name</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
<td>Varicella, Measles, Mumps, Haemophilus</td>
</tr>
<tr>
<td>Information Shown</td>
<td></td>
</tr>
</tbody>
</table>

4. HISTORY OF DISEASE

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
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</tr>
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</table>

5. ALLERGIES

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peanut</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shellfish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pollen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. SUBSTANCE ABUSE TREATMENT

<table>
<thead>
<tr>
<th>Substance</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. SOCIAL HISTORY

<table>
<thead>
<tr>
<th>Income per year</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Marital Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. FAMILY HISTORY

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
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<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. OCCUPATIONAL HISTORY

<table>
<thead>
<tr>
<th>Industry</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manufacturing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Construction</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

11. ENVIRONMENTAL HISTORical

<table>
<thead>
<tr>
<th>Exposure</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artistic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Check if you have or ever worked in the following industries or have had significant occupational or environmental exposure to the following:

- Asbestos
- Benzene
- Beryllium
- Cadmium
- Carbon Tetrachloride
- Chemical Plant
- Construction Site
- Cotton, Textile
- Disinfection
- Electronic Plant
- Fiberglass
- Flax
- Nuclear Industry
- Repair, Lumber Mill
- Pesticides
- Plastics
- Phenol

13. Check if you have or ever worked in the following industries or have had significant occupational or environmental exposure to the following:

- Lead
- Mercury
- Metal Finishes
- Nails
- Neoprene
- Pesticides
- Plastics

14. Do you have any hobbies that include:

- Soil work
- Weight lifting
- Exposure to lead, arsenic, glass or fumes

15. Have you ever worn personal protective equipment such as:

- Respirator, Hearing Protection, Glasses, Safety Glasses, Protective Clothing

16. Did you have difficulty with this equipment?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

17. Have you received medical examinations as part of a prior job? If yes, what year?

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. What year was your house built?

<table>
<thead>
<tr>
<th>Year</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. Are pesticides used in your home or garden?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

20. If yes, is a licensed pest control or a licensed pest control operator employed?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

21. Did you ever live near a facility that could have contaminated your home environment such as a dump, hazardous waste site, manufacturing plant, gas station?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

22. Have you ever changed your residence because of a health problem?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

23. Where do you get your drinking water?

<table>
<thead>
<tr>
<th>City</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24. Have you recently purchased new furniture or carpet or remodeled your home?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

25. In your home, do you have:

- Bubbling Hot Water Heaters
- Electric Hot Water Heaters
- Gas Hot Water Heaters

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

26. Do any of your health problems have any relationship to your environmental activities?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

I certify that the above is true to the best of my knowledge.

Patient Signature: ___________________________ 
Reviewers/Examiners: ________________________ Date: ___________
### Patient-Employer Profile

**Company Info**
- **Current Company Name:** QCA
- **Company #:** 545461-4
- **ID:** WT24477
- **SIC Code:** 8099
- **NAICS Code:** 623110
- **Company Type:** Health Care and Social Assistance
- **Current Occupation:** Nursing Aides, Orderlies, and Attendants
- **Co Address:** 255 MADISON AVE
- **City:** SAINT LOUIS
- **State:** MO
- **Zip:** 63118
- **Co Phone:** (800) 265-0656
- **Co Fax:**
- **# of Employees:**
- **FEIN:**

**Prior Company Name:**
- **Company #:**
- **ID:**
- **SIC Code:**
- **NAICS Code:**
- **Company Type:**
- **Prior Occupation:**
- **Co Address:**
- **City:**
- **State:**
- **Zip:**
- **Co Phone:**
- **Co Fax:**
- **# of Employees:**
- **FEIN:**

**Procedures Required by the Employer**
- **Exams**
  - DOT Exam
  - Injury Exam
  - Return to Work Exam
  - Exit Exam
  - Preplacement Exam
  - Impairment and disability assessment
  - Respirator protection medical clearance
- **Services**
  - Education
  - Industrial hygiene services
  - Other
  - Health fair
  - Respirator Fit Test
  - On site

**Notes:**

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*Last Modified: HFA_eApp (3/26/2013 10:24:26 AM)*
SIC Code/NAICS Code

SIC Code: 8059
NAICS Code: 623110

SIC Code Search

<table>
<thead>
<tr>
<th>No</th>
<th>SIC Code</th>
<th>SIC Desc</th>
<th>SIC Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7231</td>
<td>BEAUTY SHOPS</td>
<td>SERVICES</td>
</tr>
</tbody>
</table>

NAICS Code Search

<table>
<thead>
<tr>
<th>No</th>
<th>NAICS Code</th>
<th>NAICS Desc</th>
<th>NAICS Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>446120</td>
<td>COSMETICS, BEAUTY SUPPLIES, AND PERFUME STORES</td>
<td>RETAIL TRADE</td>
</tr>
<tr>
<td>2</td>
<td>812112</td>
<td>BEAUTY SALONS</td>
<td>OTHER SERVICES(EXCEPT PUB ADMIN)</td>
</tr>
</tbody>
</table>
**History of Present Illness - Includes Work Temporal Relationship Questions**

**Patient Demographics**
- Patient Name: Whitmore, Amy
- Gender: Male
-DOB: 6/4/1965
- Age: 56
- Established: Y
- Race: American Indian and Alaska Native (AIA) alone
- Marital Status: Married
- Companion: Insurance
- Group No.: Plan Code
- Employee: CNA

**Established**
- Diagnosis of back pain
- Onset of pain: "Back pain, radiculopathy, low back pain (Acute)"
- Date: 05/31/2011
- Problem Type: Diagnosis

**Symptoms**
- Location: Back
- Severity at best: 8/10
- Severity at worst: 5/10
- Duration: 5 days
- Frequency: Constantly

**EMR - HPI (History of Present Illness)**

**Chief Complaint / History of Present Illness (HPI)**
- History Source:
  - Spouse: Yes
  - Other: No

**EMR - HPI Comments**
- Lifting patient at work, helping them transfer them from the chair to the bed, patient started to fall, twisted my back trying to prevent patient from falling. Felt my back go into spasm with radiating pain down the left leg. Patient was over 160 lbs, no one available to help. Off work during the last 2 days with shift change, pain heart improved with mobility last 2 days, difficulty sleeping, unable to sit for more than 30 min and unable to bend to tie shoes without severe pain.
Low Back Pain Template

Questions Regarding Low Back Pain

1. Have you ever had low back and leg pain?
   - Yes
   - No

2. Have you ever had back pain?
   - Yes
   - No

3. Have you ever had any symptoms of sciatica or spinal stenosis?
   - Yes
   - No

4. Have you ever had sciatica pain?
   - Yes
   - No

5. Have you ever had any constant, persistent, non-mechanical pain?
   - Yes
   - No

6. Have you ever had any persistent severe restriction of lumbar flexion?
   - Yes
   - No

7. Have you ever had worsening back pain?
   - Yes
   - No

8. Have you ever had a history of herniated disk?
   - Yes
   - No

9. Have you ever had a history of sciatica?
   - Yes
   - No

10. Have you ever had a history of sciatica?
    - Yes
    - No

11. Have you ever had any history of orthopedic trauma?
    - Yes
    - No

12. Have you ever had a history of dislocation?
    - Yes
    - No

13. Have you ever had a history of radiculopathy?
    - Yes
    - No

14. Have you ever had a history of herniated disk?
    - Yes
    - No

15. Have you ever had a history of spinal stenosis?
    - Yes
    - No

16. Have you ever had a history of sciatica?
    - Yes
    - No

17. Have you ever had a history of orthopedic trauma?
    - Yes
    - No

18. Have you ever had a history of orthopedic trauma?
    - Yes
    - No

19. Have you ever had any history of cancer?
    - Yes
    - No

20. Have you ever had severe back pain?
    - Yes
    - No

21. Have you ever had chronic headaches?
    - Yes
    - No

22. Have you ever had any history of head injury?
    - Yes
    - No

23. Have you ever had a history of head injury?
    - Yes
    - No

24. Have you ever had a history of low back pain?
    - Yes
    - No

25. Have you ever had a history of low back pain?
    - Yes
    - No

26. Have you ever had a history of lifting and forward movement?
    - Yes
    - No

27. Have you ever had a history of bending and twisting (awkward postures)?
    - Yes
    - No

28. Have you ever had a history of whole body vibration (WBV)?
    - Yes
    - No

29. Have you ever had a history of static postures?
    - Yes
    - No

30. Have you ever had a history of heavy lifting?
    - Yes
    - No

31. Have you ever had a history of job stress?
    - Yes
    - No

32. Have you ever had a history of job satisfaction?
    - Yes
    - No

33. Have you ever had a history of psychological health (depression and anxiety)?
    - Yes
    - No

34. Have you ever had a history of monotonous workload?
    - Yes
    - No

35. Have you ever had a history of working with jacks, hammers, sawing, overhead, or structures, or laying stones?
    - Yes
    - No

36. Were your symptoms better or worse when you are at work?
    - Better
    - Worse

37. Do you think your health problems are related to your work?
    - Yes
    - No

38. Have you ever been exposed to dust, fumes, chemicals, radiation, loud noise, hazardous materials, or physical work?
    - Yes
    - No

39. Have you ever been exposed to dust, fumes, chemicals, radiation, loud noise, hazardous materials, or physical work?
    - Yes
    - No
### Questions Regarding Lead (Inorganic)

1. Have you ever had a personal history of major illness or injury?  
   - Yes  
   - No
2. Is your work exposure history current?  
   - Yes  
   - No
3. Have you ever had personal history of hospitalization or surgery?  
   - Yes  
   - No
4. Have you ever had personal history of cancer?  
   - Yes  
   - No
5. Have you ever had personal history of back injury?  
   - Yes  
   - No
6. Do you drink 0 or more drinks per week (beer, wine, liquor)?  
   - Yes  
   - No
7. Have you ever smoked?  
   - Yes  
   - No
8. Do you currently smoke (cigarette)?  
   - Yes  
   - No
9. Have you ever had personal history of heart disease, high blood pressure, or stroke?  
   - Yes  
   - No
10. Current medication use (prescription or OTC)?  
    - Yes  
    - No
11. Have you ever had personal history of medication allergies?  
    - Yes  
    - No
12. Have you ever had personal history of any reproductive health concerns?  
    - Yes  
    - No
13. Have you ever had personal history of blood diseases (anemias)?  
    - Yes  
    - No
14. Have you ever had personal history of headaches, dizziness, light headedness, weakness?  
    - Yes  
    - No
15. Have you ever had personal history of weight loss of 10lbs or more without dieting?  
    - Yes  
    - No
16. Have you ever had personal history of change of loss of vision?  
    - Yes  
    - No
17. Have you ever had personal history of change of loss of hearing?  
    - Yes  
    - No
18. Have you ever had personal history of frequent pain or tightness in chest?  
    - Yes  
    - No
19. Have you ever had personal history of palpitations?  
    - Yes  
    - No
20. Have you ever had personal history of insomnia or sleep disturbances?  
    - Yes  
    - No

### Lead Toxicity Template

21. Have you ever had personal history of unexplained fatigue?  
    - Yes  
    - No
22. Have you ever had personal history of chronic abdominal pain, vomiting, diarrhea or symptoms?  
    - Yes  
    - No
23. Have you ever had personal history of childbearing disease?  
    - Yes  
    - No
24. Have you ever had personal history of muscle or joint problems?  
    - Yes  
    - No
25. Current pregnancy (yes or no)?  
    - Yes  
    - No
26. Have you ever had personal history of impotence or sexual dysfunction?  
    - Yes  
    - No
27. Have you ever had personal history of infertility or miscarriage (self or spouse)?  
    - Yes  
    - No
28. Have you ever had personal history of problems with numbness, tingling, weakness?  
    - Yes  
    - No
29. Have you ever had personal history of depression, difficulty concentrating, excessive anxiety in hands or feet?  
    - Yes  
    - No
30. Have you ever had personal history of personality change?  
    - Yes  
    - No
31. Is there lab/PE consistent with exposed?  
    - Yes  
    - No
32. Are any abnormalities related to exposure/exposure?  
    - Yes  
    - No
33. Have you ever had personal history of unusual taste in mouth/changes in taste of food?  
    - Yes  
    - No
34. Have you ever had personal history of abnormal menses (women)?  
    - Yes  
    - No
35. Have you ever had personal history of irritability, nervousness, tremulousness?  
    - Yes  
    - No
36. Have you ever had personal history of impairment of short term memory?  
    - Yes  
    - No
37. Have you ever had personal history of adverse reproductive outcomes?  
    - Yes  
    - No
38. Please provide written opinion required?  
    - Yes  
    - No
39. Are your symptoms better, worse or unchanged when you are at work?  
    - Yes  
    - No
40. Do you think your health problems are related to your work?  
    - Yes  
    - No
### Questions Regarding Asthma

1. Have you ever had any upper respiratory infections? [ ] Yes [ ] No
2. Have you ever had any wheezing? [ ] Yes [ ] No
3. Have you ever had shortness of breath? [ ] Yes [ ] No
4. Have you ever had any skin changes? [ ] Yes [ ] No
5. Did the symptoms start after starting new job? [ ] Yes [ ] No
6. Did the symptoms start after new materials were introduced? [ ] Yes [ ] No
7. Did the symptoms develop minutes or hours after exposure? [ ] Yes [ ] No
8. Is the frequency of symptoms frequent when away from work or on vacation? [ ] Yes [ ] No
9. Did symptoms occur more frequently upon return to work? [ ] Yes [ ] No
10. Did symptoms get progressively worse by the end of the work week? [ ] Yes [ ] No
11. Do symptoms get better on weekends or holidays? [ ] Yes [ ] No
12. Are there other workers affected? [ ] Yes [ ] No
13. Have you ever had history of anaphylaxis? [ ] Yes [ ] No
14. Have you ever had history of severe life-threatening asthma exacerbations requiring hospitalization? [ ] Yes [ ] No
15. Have you ever had history of lung/asthma infections? [ ] Yes [ ] No
16. Have you ever had history of emphysema? [ ] Yes [ ] No
17. Have you ever had history of bronchitis? [ ] Yes [ ] No
18. Have you ever had history of allergic rhinitis? [ ] Yes [ ] No
19. Have you ever had history of asthma? [ ] Yes [ ] No
20. Have you ever had history of diabetes? [ ] Yes [ ] No
21. Have you ever had history of gastroesophageal reflux? [ ] Yes [ ] No
22. Have you ever had history of urticaria? [ ] Yes [ ] No
23. Have you ever had history of atopic dermatitis? [ ] Yes [ ] No
24. Have you ever had history of food allergies? [ ] Yes [ ] No
25. Does your family have history of asthma or allergies? [ ] Yes [ ] No
26. Have you ever had any work history of exposure to dusts, chemicals, animals, irritating gases, fumes, vapors, allergens or smoke? [ ] Yes [ ] No
27. Have you ever had any work history of exposure to mold or other fungal growth, insects? [ ] Yes [ ] No
28. Are you now or have you previously been exposed to dusts, fumes, chemicals, radiation, loud noise, heavy or repeated physical work eg lifting? [ ] Yes [ ] No
29. Do you think your health problems are related to your work? [ ] Yes [ ] No
30. Are your symptoms better, worse or unchanged when you are at work? [ ] Yes [ ] No
## Questions Regarding Formaldehyde

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Have you ever had personal history of allergies (asthma, hay fever, eczema)?</td>
<td></td>
<td></td>
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<tr>
<td>Have you ever had personal history of skin disease?</td>
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<tr>
<td>Have you ever had personal history of recurrent skin rash?</td>
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<tr>
<td>Have you ever had personal history of hepatitis or jaundice?</td>
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<tr>
<td>Have you ever had personal history of lung/resp disease (ex: COPD, bronchitis, pneumonitis)?</td>
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<tr>
<td>Have you ever had personal history of headache, dizziness, light-headedness, weakness?</td>
<td></td>
<td></td>
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<tr>
<td>Have you ever had personal history of contact lens use?</td>
<td></td>
<td></td>
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<tr>
<td>Have you ever had personal history of eye irritation?</td>
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<tr>
<td>Have you ever had personal history of swelling in legs or feet (not caused by walking)?</td>
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<tr>
<td>Have you ever had personal history of coughing up blood (hemoptysis)?</td>
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<tr>
<td>Have you ever had personal history of shortness of breath?</td>
<td></td>
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<tr>
<td>Have you ever had personal history of cough (dry or productive)?</td>
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<tr>
<td>Have you ever had personal history of problems with numbness, tingling, weakness in hands or feet?</td>
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<tr>
<td>Have you ever had personal history of depression, difficulty concentrating, excessive anxiety?</td>
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<tr>
<td>Have you ever had work history of prior respirator use?</td>
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<tr>
<td>Have you ever had work history of exposure to formaldehyde?</td>
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<tr>
<td>Have you ever had family history of cancers (leukemia, tumors)?</td>
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<tr>
<td>Is surveillance/PPE consistent with exposures?</td>
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<tr>
<td>Are any abnormalities related to exposures/occupations?</td>
<td></td>
<td></td>
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<tr>
<td>No.</td>
<td>Category</td>
<td>Abbreviation</td>
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</tr>
<tr>
<td>1</td>
<td>Anesthetic Gases</td>
<td>Anesthetic, Gases, Anesthetic Gases</td>
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<td>2</td>
<td>Arsenic and Exposure</td>
<td>Arsenic</td>
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<tr>
<td>3</td>
<td>Asbestos Current Worker</td>
<td>Asbestos Current Worker</td>
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<tr>
<td>4</td>
<td>Asbestos Past Worker Exposure</td>
<td>Asbestos Past Worker - 0 to 10 Years Since First Exposure</td>
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<tr>
<td>5</td>
<td>Asthma</td>
<td>Asthma, cough, coughing and wheezing</td>
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<tr>
<td>6</td>
<td>Benzene</td>
<td>Benzene</td>
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<tr>
<td>7</td>
<td>Beryllium</td>
<td>Beryllium</td>
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<td>8</td>
<td>Blood and/or Body Fluids</td>
<td>Blood and Body Fluids, Blood or Body Fluids</td>
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<td>9</td>
<td>Cadmium (Current Exposure)</td>
<td>Cadmium</td>
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<tr>
<td>10</td>
<td>Cadmium (Past Exposure)</td>
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<tr>
<td>11</td>
<td>Carbon Disulfide</td>
<td>Carbon, Disulfide</td>
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<tr>
<td>12</td>
<td>Carbon Monoxide</td>
<td>Carbon, Monoxide</td>
</tr>
<tr>
<td>13</td>
<td>Chronic Acid/Chromium (VI)</td>
<td>VI, Chronic Acid, Chromium (VI)</td>
</tr>
<tr>
<td>14</td>
<td>Coal Tar Pitch Vol/Polymeric Aromatic Hydrocarbon</td>
<td>Coal Tar Pitch Vol., Polymeric Aromatic Hydrocarbon</td>
</tr>
<tr>
<td>15</td>
<td>Cold</td>
<td></td>
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<tr>
<td>16</td>
<td>Distal Upper Extremity</td>
<td>Musculoskeletal Disorders of the Distal Upper Extremity, Work-Related Musculoskeletal Disorders</td>
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<tr>
<td>17</td>
<td>DOT exam</td>
<td>DOT, DOT vehicle operators exam, DOT vehicle operators, DEPARTMENT OF TRANSPORTATION (DOT) VEHICLE OPERATORS</td>
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<tr>
<td>18</td>
<td>Ethylene Oxide</td>
<td>Ethylene, Oxide</td>
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<tr>
<td>19</td>
<td>FIREFIGHTER ANNUAL HEALTH SCREEN</td>
<td>FIREFIGHTER HEALTH SCREEN, Health Screening exam for firefighters</td>
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<td>20</td>
<td>FIREFIGHTER PREPLACEMENT AND PERIODIC</td>
<td>FIREFIGHTER PREPLACEMENT exam, PREPLACEMENT, PERIODIC, FIREFIGHTER</td>
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<td>21</td>
<td>Formaldehyde</td>
<td>coughing and wheezing, nasal congestion</td>
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<tr>
<td>22</td>
<td>Hazardous Drugs</td>
<td>Hazardous Drugs, Drugs</td>
</tr>
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<td>23</td>
<td>HAZARDOUS WASTE WORKERS AND EMERGENCY RESPONDERS</td>
<td>HAZARDOUS WASTE WORKERS, EMERGENCY RESPONDERS, HAZARDOUS WASTE</td>
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<td>24</td>
<td>HEALTHCARE WORKERS (HCWS)</td>
<td>HEALTHCARE WORKER, HCWS</td>
</tr>
<tr>
<td>25</td>
<td>Heat</td>
<td>Heat</td>
</tr>
<tr>
<td>26</td>
<td>Herbicides</td>
<td>Herbicides</td>
</tr>
<tr>
<td>27</td>
<td>Isoxynates</td>
<td>Isoxynates</td>
</tr>
<tr>
<td>28</td>
<td>Lead (Inorganic)</td>
<td>Lead, joint pains, fatigue and occasional stomach pain</td>
</tr>
<tr>
<td>29</td>
<td>Low Back Pain</td>
<td>Low Back Pain</td>
</tr>
<tr>
<td>30</td>
<td>Manmade Mineral Fibers</td>
<td>Mineral Fibers</td>
</tr>
<tr>
<td>31</td>
<td>Metal Fumes</td>
<td>Metal Fumes, Metal, Fumes</td>
</tr>
<tr>
<td>32</td>
<td>Metal Working Fluids</td>
<td>Metal, Metal Working Fluids</td>
</tr>
<tr>
<td>33</td>
<td>Mixed Solvents</td>
<td>Mixed Solvents, Solvents, Solvent</td>
</tr>
<tr>
<td>34</td>
<td>Nickel (Inorganic)</td>
<td>Nickel</td>
</tr>
<tr>
<td>35</td>
<td>Nickel Carbonyl</td>
<td>Nickel, Carbonyl</td>
</tr>
<tr>
<td>36</td>
<td>Noise</td>
<td>Noise</td>
</tr>
<tr>
<td>37</td>
<td>Noise - Follow Up Of STS (#1 And/Or #2)</td>
<td>Noise, Follow Up Of STS, STS, Noise - Follow Up Of STS</td>
</tr>
</tbody>
</table>
## Occupational History

### Past Medical Hx | Past Surg & Hosp Hx | Current Medications | Allergy/Adverse Reactions

<table>
<thead>
<tr>
<th>Genetic</th>
<th>Environmental Hx</th>
<th>Occupational Hx</th>
<th>Exposure Hx</th>
</tr>
</thead>
</table>

**OCCUPATIONAL HISTORY**

**WHAT IS YOUR CURRENT OR MOST RECENT EMPLOYMENT?**

- **NAME OF EMPLOYER:** CNA  
- **JOB TITLE:** Nursing Aides, Orderlies, and Attend  
- **DATE STARTED:**

**REGULAR WORK PLACE** (Building and Room No.)

- **Street Address:** 266 Madison Ave  
- **APARTMENT NO.:**

**CITY:** Medford  
**STATE:** NY  
**ZIP CODE:** 11763

**JOB DESCRIPTION**

Provide basic patient care under direction of nursing staff. Perform duties, such as feed, bathe, dress, groom, or move patients, or change linens. Turn and reposition bedridden patients, alone or with assistance, to prevent bed sores. Answer patients' call signals. Feed patients who are unable to feed themselves. Observe patients' conditions, measuring and recording food and liquid intake and output and vital signs, and report changes to professional staff. Provide patient care by supplying and emptying bed pans, applying dressings and supervising exercise routines.

**CURRENT JOB STATUS**

- [ ] FULL TIME  
- [ ] PART-TIME  
- [ ] MULTIPLE JOBS (HRS/WK)  
- [ ] RETIRED - SINCE WHAT YEAR:  
- [ ] OTHER:

**DOES YOUR PRESENT JOB REQUIRE WORK DURING SHIFTS OTHER THAN THE DAY SHIFT?**

- [ ] YES, ONLY OVERTIME  
- [ ] IRREGULAR HOURS  
- [ ] YES, REGULARLY (CHECK BELOW)  
- [ ] YES, ROTATING SHIFTS  
- [ ] SWING SHIFT  
- [ ] GRAVEYARD SHIFT

**SECOND JOB?**

- [ ] NO  
- [x] Yes  
- **JOB TITLE:**

**WHEN IT IS APPROPRIATE, DO YOU WEAR ANY OF THE FOLLOWING PROTECTIVE EQUIPMENT IN YOUR CURRENT OR MOST RECENT JOB?**

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Not Needed</th>
<th>Needed But Never Used</th>
<th>Occasional</th>
<th>About Half the Time</th>
<th>All the Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mask Respirator</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>[x]</td>
</tr>
<tr>
<td>Air Supply Respirator</td>
<td>[x]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves</td>
<td></td>
<td>[x]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverall or Aprons</td>
<td></td>
<td>[x]</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Safety Glasses</td>
<td>[x]</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hearing Protection</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**ON YOUR CURRENT OR MOST RECENT JOB, DO YOU:**

- **USE SEPARATE WORK CLOTHES?**  
- [ ] NO  
- [x] YES  
- **HAVE A LUNCHROOM AWAY FROM WORK EXPOSURE?**  
- [ ] NO  
- [x] YES

- **TAKE WORK CLOTHES HOME?**  
- [ ] NO  
- [x] YES  
- **IF YES, DO YOU USE IT?**  
- [ ] NO  
- [x] YES

- **USE SEPARATE WORK SHOES?**  
- [ ] NO  
- [x] YES  
- **SMOKE OR USE CHewing TOBACCO WHILE WORKING?**  
- [ ] NO  
- [x] YES

**HOW MANY PEOPLE WORK IN YOUR COMPANY OR PLANT?**

- [ ]

**HOW MANY PEOPLE WORK IN YOUR IMMEDIATE WORK AREA?**

- [ ]
### Occupational History

<table>
<thead>
<tr>
<th>COMPANY NAME OR TYPE OF BUSINESS</th>
<th>FROM (MONTH/YEAR)</th>
<th>TO (MONTH/YEAR)</th>
<th>JOB TITLE OR DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>cleaview nursing home</td>
<td>02 / 2004</td>
<td></td>
<td>CNA</td>
</tr>
<tr>
<td>riverview residential facility</td>
<td>01 / 2000</td>
<td>11 / 20</td>
<td>cna</td>
</tr>
<tr>
<td>sams clothing</td>
<td></td>
<td>05 / 1995</td>
<td>clerk</td>
</tr>
</tbody>
</table>

IS THERE A UNION AT YOUR CURRENT OR MOST RECENT JOB?
- [ ] NO
- [ ] YES, WHAT UNION? (specify)
- [ ] YES, MEMBERSHIP: NO
- [ ] INACTIVE
- [ ] ACTIVE

HAVE YOU EXPERIENCED EMOTIONAL STRESS AT YOUR CURRENT OR MOST RECENT JOB?
- [ ] NO
- [ ] YES, SPECIFY: layoffs

HAVE YOU EXPERIENCED SATISFACTION OR REWARD AT YOUR CURRENT OR MOST RECENT JOB?
- [ ] NO
- [ ] YES, SPECIFY: good supervisor

WERE YOU EVER GIVEN JOB SAFETY OR HEALTH TRAINING FOR YOUR CURRENT OR MOST RECENT JOB?
- [ ] NO
- [ ] YES

IF YES, BY WHOM?
- [ ] MANAGEMENT
- [ ] UNION
- [ ] OTHER: Respirator fit test

START WITH THE JOBS YOU HELD BEFORE THIS ONE, AND LIST ALL THE JOBS YOU HAVE HAD, INCLUDE MILITARY SERVICE AND ANY PART-TIME JOBS.
Exposure History- with AOEC exposure codes
Patient: PAGE, JACQUELINE A    Gender: Female    Age: 33    MRN: HPA1500714190

Progress Note

Patient History

Chief Complaint / HPI: Coughing and Wheezing, Severity: 6/10 - 8/11, Frequency: Constantly; cough / wheeze
1. Has your cough begun recently? Yes
2. Does your cough produce clear or pale yellow mucus? Yes
3. Does your cough produce yellow, green or green mucus? No
4. Does the cough come with shortness of breath and wheezing? Yes
5. Do you have swelling in your legs and/or shortness of breath when you are active or after you have been lying down? No
6. Do you have heart problems? No
7. Have you recently started coughing up blood or bloody sputum? No
8. Have you unintentionally lost weight? No

33 yr old female was in good health until about 1 yr ago when she began to cough and wheeze, attacks occurring more frequently. Frequently tired, headaches, nasal congestion. History of allergies to pollen. Uses her inhaler more at work, 2-3 times per day and once in the evening. She said after she filled out the questionnaires, she realized that she uses her inhaler more at work. Her problem may be related to her work. Admits to exposure to fumes at work, stylists next to her began using brazilian blowout and new nail treatment in hair salon where she works. Headaches worse at end of the day.

Said last attack before this past year was when she was a teenager.

Occupational History:
Name of Employer: Hoshall's Hair Salon
Job Title: Hairdressers, Hairstylists, and Cosmetologists
Regular Work Place: 362 COLCHESTER AVE, ST LOUIS, MO 63116
Job Description: Keep work stations clean and sanitize tools such as scissors and combs. Cut, trim and shape hair or hairpieces based on customers' instructions, hair type and facial features, using clippers, scissors, trimmers and razors. Analyze patrons' hair and physical features to determine and recommend beauty treatment or suggest hair styles. Schedule client appointments. Bleach, dye, or tint hair, using applicator or brush. Update and maintain customer information records, such as beauty services provided. Shampoo, rinse, condition and dry hair and scalp or hairpieces with water, liquid scalp, or other solutions. Operate cash registers to receive payments from patrons. Demonstrate and sell hair care products and cosmetics. Develop new styles and techniques. Apply water, setting, etc.

DOES YOUR PRESENT JOB REQUIRE WORK DURING SHIFTS OTHER THAN THE DAY SHIFT?

Exposure History: FORMALDEHYDE AT WORK; TOI UNE DIOROCYANATE AT WORK
# Physical Exam: Musculoskeletal Includes Required WCB Information (c4)

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>General Appearance</th>
<th>Skin</th>
<th>Head - Face</th>
<th>Eyes</th>
<th>Ears</th>
<th>Nose</th>
<th>Mouth and Throat</th>
<th>Neck</th>
<th>Psychiatric</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest - Breast - Axilla</td>
<td>Cardiovascular</td>
<td>Respiratory</td>
<td>Gastrointestinal</td>
<td>Genitourinary</td>
<td>Extremities</td>
<td>Musculoskeletal</td>
<td>Lympathic</td>
<td>Neurological</td>
<td>Summary</td>
<td>Show All</td>
</tr>
<tr>
<td>No Visible ULCR/CVA Tenderness</td>
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<td></td>
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<td>Normal Tension Off Spine</td>
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<tr>
<td>GIB (Gibbus) - Negative</td>
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<tr>
<td>SLR (Straight Leg Lift) - Negative</td>
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<td>Normal Posture - The Neck</td>
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</table>

## Musculoskeletal

- Abnormal/Restricted ROM
- Active ROM
- Drying
- Humm
- Circulation
- Deformity
- Edema
- Quilt

## Abnormal/Restricted ROM
- Neurovascular Findings
- Other Findings (Specify)
- Palpable Masses

## No Visible ULCR/CVA Tenderness
- Normal Tension Off Spine
- GIB (Gibbus) - Negative
- SLR (Straight Leg Lift) - Negative

## Normal Posture - The Neck
- Overall Normal

## Decreased Rotation
- Decreased Side Bending
- Rami Ulnaris Tenderness

## Cervical Compression
- Cervical ROM - Extension (0-60)
- Cervical ROM - Flexion (0-60)
- Cervical ROM - Left Lateral Flexion (0-45)
- Cervical ROM - Right Lateral Flexion (0-45)

## Cervical ROM
- Left Rotation (0-45)
- Right Rotation (0-45)
- Extension (0-60)
- Flexion (0-60)

## No Visible CVA Tenderness
- No Visible ULCR/CVA Tenderness

## Normal Tension Off Spine
- GIB (Gibbus) - Negative
- SLR (Straight Leg Lift) - Negative

## Radiographs
- Normal Radiographs
- Abnormal Radiographs

## Neurovascular Findings
- Motor Deficit
- Sensory Deficit

## Other Findings (Specify)
- Pain Tenderness
- Palpable Masses

## Palpable Masses
- Masses
- Lymph Nodes

## Normal Posture - The Neck
- Overall Normal

## Decreased Rotation
- Decreased Side Bending
- Rami Ulnaris Tenderness

## Cervical Compression
- Cervical ROM - Extension (0-60)
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- Cervical ROM - Right Lateral Flexion (0-45)

## Cervical ROM
- Left Rotation (0-45)
- Right Rotation (0-45)
- Extension (0-60)
- Flexion (0-60)

## No Visible CVA Tenderness
- No Visible ULCR/CVA Tenderness

## Normal Tension Off Spine
- GIB (Gibbus) - Negative
- SLR (Straight Leg Lift) - Negative

## Radiographs
- Normal Radiographs
- Abnormal Radiographs

## Neurovascular Findings
- Motor Deficit
- Sensory Deficit

## Other Findings (Specify)
- Pain Tenderness
- Palpable Masses

## Palpable Masses
- Masses
- Lymph Nodes
## Diagnosis/Plan/Assessment

<table>
<thead>
<tr>
<th>No</th>
<th>Symptoms</th>
<th>Diagnosis</th>
<th>Plan</th>
<th>Notes</th>
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<td>Hypertension, benign</td>
<td>401.1</td>
<td>Rx INJ LAB DIAOS REF Followup NYMG</td>
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</table>
WCB: C4 Form-auto populated from History and Exam

State of New York – Women’s Compensation Board

THIS FORM MAY ONLY BE SUBMITTED ELECTRONICALLY. DO NOT MAIL.

This form may be used to report the first time you treated the patient or to report continuing services. (To report permanent impairment, use Form C-4.) Use this form only if attached a detailed narrative report. Please answer all questions completely and submit promptly to the Board, the insurance carrier, and to the patient’s attorney or licensed representative, if he/she has one; if not send a copy to the patient. Failure to do so may delay the payment of necessary treatment, prevent the timely payment of wage loss benefits to the injured worker, create the necessity for testimony, and jeopardize your Board authorization.

A. Patient’s Information
1. *Last Name: AMY  *First Name: AMY  MI:
2. Social Security #: 545-55-4664  3. Home Phone #: 509-211-5614
4. WCB Case #: (if unknown leave blank): 5. Carrier Case (if unknown leave blank):
6. *Mailing Address: 4 ALEXANDER LANE  Line 2: 
   *City:    Medford  State:  NY  Zip Code:  11762  *Country: USA
10. *On the date of injury/illness what was the patient’s job title or description:
11. *On the date of injury/illness what were the patient’s usual work activities:
Lifting patient was used, helping them transfer from the chair to the bed, patient started to fall, located my basic trying to prevent patient from falling. Fall my
12. *Is the patient working now?  Yes  No  13. Patient’s Account #: HPA1593714239

B. Employer Information
1. Employer when injury occurred:  *Company/Agency Name:
2. Employer Phone #: 3. *Employer Address: Line 2:  
   *City:  State:  Zip Code:  *Country: USA

C. Doctor’s Information
1. *Your Last Name:  *First Name:  MI:  
2. *WCB Authorization #:  
3. *WCB Rating Code:  
4. *Federal Tax ID #: The Tax ID # is the (check one):  SBN  EIN
5. *Office Address: Line 2:
   *City:  State:  Zip Code:  *Country: USA
6. Billing Group / Practice Name:
7. *Billing Address:  Line 2:  
   *City:  State:  Zip Code:  *Country: USA
10. Treating Provider’s NPI #:  11. *You are a (select one):  ☐ Physician  ☐ Podiatrist  ☐ Chiropractic

D. Billing Information
1. Employer’s insurance carrier:  Unknown
2. Carrier Code #:  
3. Insurance carrier’s address:  Line 2:
   City:  State:  Zip Code:  *Country: USA
4. Diagnosis or nature of disease or injury: Line 1  ICD9 Code  ICD9 Descriptor

Relate ICD9 codes above to Diagnosis Code column by line:

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Place of Service</th>
<th>Leave Blank</th>
<th>Use WCB Codes</th>
<th>Procedure, Services, or Supplies</th>
<th>CPT/HCPCS Modifier 1 Modifier 2</th>
<th>Diagnosis Code</th>
<th>$ Charges</th>
<th>Days/Units</th>
<th>COB</th>
<th>Zip Code where service was rendered</th>
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</table>

Service were provided by a WCB preferred provider organization (PPO)

<table>
<thead>
<tr>
<th>Total Charge</th>
<th>Amount Paid (Carrier Use Only)</th>
<th>Balance Due (Carrier Use Only)</th>
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</thead>
</table>
## NYS- OHNIS Patient Information

**Check referrals to specialist:**
- Allergy
- ENT
- Neurology
- Primary Care
- Pulmonary
- Cardiology
- Ergonomics
- Orthopedics
- Psychology/Psychiatry
- Social Worker
- Dermatology
- Gastroenterology
- Pain Clinic
- PT/Rehab
- Urology
- Endocrinology
- I. Hygiene
- Others

**Was the patient visit WTC related?:** Yes □ No □

**Patient Type:**
- Occupational the exposure is from their current or past occupation
- Environmental the exposure is from the non-occupational environment
- Family the exposure is a result of a family member

**Group screening (Check one only):**
- Asbestos/Respirator
- Hazardous Material Responder
- Lead
- Respirator Clearance
- Other
- Asbestos
- Carbon monoxide
- Hearing
- Heavy Metals (other than lead)
- Lyme
- Pesticides
- Scheduled
- Skin Cancer
- Exposed group/cohort
- Hepatitis
- Pre-placement
- Termination

### DIAGNOSIS / AGENT - WORK AND NON WORK RELATED DIAGNOSES

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Dx: ICD-9 code</th>
<th>Dx: ICD-9 code</th>
<th>Dx: ICD-9 code</th>
<th>Dx: ICD-9 code</th>
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<tr>
<td>Agent 1 Name</td>
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<tr>
<td>Agent 2 Name</td>
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<tr>
<td>Work Related? (Y, N, Maybe)</td>
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<tr>
<td>Registry Reportable? (Check only one per diagnosis if applicable)</td>
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### WORK RELATED CONDITION
(Complete the following ONLY if the condition is work related)

1. **Work Status**
   - Working
   - Retired
   - Unemployed
   - Disability
   - Yes (Complete)
   - No

2a. **Has work status changed?**
   - Changed jobs
   - Returned to work with permanent restrictions
   - Unable to work
   - Returned to work with temporary restrictions
   - Less hours at same job
   - Returned to work with no restrictions
   - Retired

2b. **How has work status changed?**
   - Changed jobs
   - Returned to work with permanent restrictions
   - Unable to work
   - Returned to work with temporary restrictions
   - Less hours at same job
   - Returned to work with no restrictions
   - Retired

3. **Injury/ILLness affected ability to perform (Check at least one)**
   - Tasks around the house
   - Provide care to family/ children
   - Recreation
   - None
### Return to Work (RTW) Form

**ACTIVITY PRESCRIPTION FORM (APF)**
Stony Brook LIOEHC/Occupational and Environmental Medicine

<table>
<thead>
<tr>
<th>Injured Worker’s Name</th>
<th>Visit Date:</th>
<th>Employer:</th>
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</thead>
<tbody>
<tr>
<td>Amy Whitmore</td>
<td>5/1/2011</td>
<td>CNA</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Doctor’s Name:</th>
<th>Date of Injury:</th>
<th>Date of 1st Visit:</th>
<th>Work Related Diagnosis:</th>
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</thead>
</table>

Worker is released to the job of injury without restrictions on: [ ]  

**Key Objective Finding(s):**  
- Lower back pain  
- Lower extremity pain  
- Lumbago  
- Numbness  
- Dizziness

Worker may perform modified duty (altered duties or limited hours), if available, from: [ ]  

- [ ]  to:  [ ]  
- See restrictions in next section.

Worker not released to any work from: 6/21/2011 to 8/8/2011

#### Restrictions:  
- [ ] Temporary Restrictions  
- [ ] Permanent Restrictions

<table>
<thead>
<tr>
<th>Worker CAN (Return to work injury’s)</th>
<th>Those left blank are not restrictions</th>
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<tbody>
<tr>
<td>L-Left, R-Right, B-Both</td>
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<tr>
<td>Bend/Stoop</td>
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<tr>
<td>Carry (L,R,B)</td>
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<td>Climb (bolder and/or stairs)</td>
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<td>Crawl</td>
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<td>Driving</td>
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<td>Extremity use (L,R,B) Arm/Leg</td>
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<td>Fine Manipulation (L,R,B)</td>
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<td>Grasp (L,R,B)</td>
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<td>Keyboard</td>
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<td>Lift (L,R,B)</td>
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<td>Moving or transferring patients</td>
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<tr>
<td>Operate foot controls (L,R,B)</td>
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</tbody>
</table>

**Continued Other Restrictions/Instructions on Restrictions:**

**Employer notified of restrictions:**  
- [ ] Y  
- [ ] N  

Data notified: 5/2/2011  
Person Notified: Jean Peter  
Modified Duty: [ ] Available [ ] Not Available  
Notes:
Educational Reference


CDC-NIOSH  [http://www.cdc.gov/NIOSH/](http://www.cdc.gov/NIOSH/)
[http://online.onetcenter.org/find/quick?s=mechanic](http://online.onetcenter.org/find/quick?s=mechanic)
Challenges & Recommendations

- **Lack of Occupational Information in most EHR**
  - Recommend: Basic 5 questions and templates to capture occupational sentinel conditions
  - Provide RTW and workers compensation assessment tools
  - Occupational medicine EHR module needed for primary care and specialist use— with employer and patient portals
  - Assists with social security determination
  - Broaden meaningful use criteria to apply to work env

- **Limited standardization**
  - Functional job description – usable, could be improved
  - Proprietary systems impede interoperability
  - Identify standardized occupational and exposure datasets
  - Standardized occupational medicine module
    - (O*Net and AOEC good starts)
Challenges & Recommendations

Insufficient resources to obtain occupational medicine
- Patient and employer portals complete info for HCP review
- Portals create hierarchy of key information for review.

- **Insufficient Knowledge**
  - Templates with questions and educational component for review for major conditions and agents
  - Referral to occupational medicine specialist

- **Placement of Data**
  - Identify exposures in Social/Occcup Hx, triggers key questions re: symptoms in prior ROS questions

- **Learning Curve**
  - Templates, Training, Emphasize end result

- **Confidentiality concerns- occupational vs non occupational**
  - Consents
  - Segregate non occupational information & stakeholder access
Challenges & Recommendations

- **Deterrents- Development and Adoption**
  - Fund or Encourage Development of Needed Modules
  - EHR Incentives- extend to all providers, stakeholder agencies
  - State programs – NYS DOH eligible for federal funding incentives
  - Interoperability Concerns

- **Need for Common Data Sets**
  - Special thanks to ACOEM, NYS-OHCN, DOL-O*Net, AOEC

- **NIOSH closing of ERC- loss of occupational medicine expertise**
  - Ensure funding of training program in occupational medicine
  - Fund/develop EMR tools for primary care and occupational medicine provider
We could access medicalTxGuides, at the point of service to improve care and outcomes. Communicate with other providers and stakeholders for improved decision making. We could speak the same language through a standardized approach and information. We could learn from each other and as we go? 

Imagine...

Track outcomes, monitor trends, conduct surveillance? Prevention occupational injury and illness. We could access medical Tx Guides, at the point of service to improve care and outcomes. We could learn from each other and as we go?
Thank You IOM and NIOSH

- Contributors to this Project:
  - E*HealthLine
  - ACOEM and Consultants
  - DOL- O*Net
  - Association of Occupational and Environmental Clinics (AOEC)
  - DOH & NYS Occupational Health Clinic Network
    - Dr. George Friedman-Jimenez
  - Stony Brook University