UnityPoint Health
Allen Hospital

Occupational Health Services
7024 Nordic Dr
Cedar Falls IA 50613
PH 319-266-3127
FAX: 319-859-3873

Name Label HERE
Employer Name

AUTHORIZATION FOR SURVEILLANCE OPINION TO EMPLOYER

Employee Name: ________________________________ Date: ___________________________

Employee DOB: _________________________________ Employer: ________________________

You are undergoing medical evaluation for surveillance of:

- ❑ Occupational Respirator Use
- ❑ Crystalline Silica
- ❑ Asbestos
- ❑ Lead
- ❑ Other: ___________________________________

This evaluation could reveal a medical condition that results in recommendations for: (1) limitations on respirator use, (2) limitations on other occupational exposure, (3) need for additional testing, or (4) evaluation by a specialist in another field of medicine. Recommended limitations on respirator use will be included in the written opinion to the employer. If you want your employer to know about additional recommendations such as limitations to other occupational exposures, need for additional testing, or need for specialist evaluation, **you will need to give authorization for the written opinion to the employer to include those since personal health information may be disclosed in doing so.**

I hereby authorize the opinion to the employer to contain the following information, if relevant:

(Check item(s) in one column only)

I authorize the following:	❑ I DO NOT authorize the opinion to the employer to contain anything other than recommended limitations on respirator use. I understand that if I do not authorize my employer to receive ALL recommendations, the employer will not be asked to schedule or provide payment for additional services needed for work ability.
❑ Recommendations for limitations on exposure. ❑ Recommendations for additional testing. ❑ Recommendations for evaluation by a Board Certified Specialist.	

This authorization expires 1 year from the signed date unless employee rescinds authorization, in writing, to Allen Occupational Health Clinical Manager.

____
Printed Name

____
Signature

____
Date

UnityPoint Health
Allen Hospital

RESPIRATOR QUESTIONNAIRE

Occupational Health
Cedar Falls Location | Phone (319) 266-3127

Name Label HERE
Employer Name

Supervisor to complete:

Employee/Applicant's Name: SS# ____________________

Date of Birth: ______________

1. Types and weight of respirators to be used:
   - ❑Atmosphere-supplying respirator, weight______
   - ❑Continuous-flow respirator, weight_________
   - ❑Open-circuit SCBA, weight__________
   - ❑Closed circuit SCBA, weight_________
   - ❑Supplied-air respirator, weight__________
   - ❑Combination air-line and SCBA, weight_______
   - ❑Air-purifying (non-powered), weight__________
   - ❑Air-purifying (powered), weight__________

2. Select the category that most closely matches the level of work to be performed while wearing respirator:

SELECTION:	ACTIVITIES	METS
	Sleeping	1
	Desk work, driving, standing in place,	1.5 – 2
	Auto repair, riding lawn mower, slow-paced walk, lift/push/pull up to 10 pounds, welding	2-3
	Bricklaying, plastering, empty wheelbarrow, welding, janitorial work, lift/push/pull up to 20 pounds	3-4
	Masonry, paperhanging, light carpentry, raking leaves, hoeing	4-5
	Digging a garden, shoveling light earth,	5-6
	Splitting wood, shoveling snow, push lawn mower, lift/carry up to 45 pounds	6-7
	Digging ditch, lift/carry up to 80 pounds, hand-sawing hard wood	7-8
	Run/Jog briskly	>8

3. Extent of usage:
   - ❑On a daily basis, Frequency:______________Duration: _______________
   - ❑Occasionally - but more than once a week, Frequency:______________Duration: _______________
   - ❑Rarely - less than once a week, Frequency:______________Duration: _______________
   - ❑Emergency use for rescue and escape, Frequency:______________Duration: _______________
4. Additional protective clothing and equipment to be worn:____
5. Temperature and humidity extremes: ____
6. Other information: ____

Date: ______________ Supervisor: ____

Employee to read:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver/send this questionnaire to the health care professional who will review it.

If you receive this questionnaire and are NOT at the clinic, please place your completed questionnaire in a sealed envelope to deliver/send to Allen Occupational Health Services. A licensed health care professional will evaluate your documentation and provide you and your company with written recommendation for obtaining a follow-up evaluation and/or your medical clearance to use a respirator. If you have any questions, please feel free to call Allen Occupational Health Services at (319) 266-3127

Employee Initials: ______

Employee to complete:

1. Can you read (please circle your response)? .... ❑❑Yes ❑ No

Part A, Section 1 - Mandatory

The following information must be provided by every employee who has been selected to use any type of respirator .

1. Today's date: ______________________ Your social security number: ______________________
2. Your last name: ______________________ Your first name: ______________________
3. Your date of birth: ______________________ Your age (to the nearest year) ______________________
4. Your height: __________ ft. __________ in. Your weight: ______________________
5. Your ethnic group: ❑Asian ❑Afro-American ❑Caucasian ❑Hispanic Sex: ❑Male ❑Female
6. Your company name: ______________________ Your job title: ______________________
7. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the area code): ______________________ The best time to phone you at this number: __________
8. Has your employer told you how to contact the health care professional who will review this questionnaire?
   ❑Yes ❑No
9. Check the type of respirator you will use (you can check more than one category):
   ❑ N,R, or P disposable respirator (filter-mask, non-cartridge type only)
   ❑ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
10. Have you worn a respirator: .... ❑ Yes ❑ No

    If "Yes", what type (s): ____

Part A, Section 2 - Mandatory

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please choose Yes or No).

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?............................... ❑ Yes ❑ No

Employee Initials: ______

2. Have you ever had any of the following conditions…
   - a. Seizures (fits)? ❑ Yes ❑ No
   - b. Diabetes (sugar disease)? ❑ Yes ❑ No
   - c. Allergic reactions that interfere with your breathing? ❑ Yes ❑ No
   - d. Claustrophobia (fear of closed-in spaces)? ❑ Yes ❑ No
   - e. Trouble smelling odors? ❑ Yes ❑ No

3. Have you ever had any of the following pulmonary or lung problems...
   - a. Asbestosis? ❑ Yes ❑ No
   - b. Asthma? ❑ Yes ❑ No
   - c. Chronic bronchitis? ❑ Yes ❑ No
   - d. Emphysema? ❑ Yes ❑ No
   - e. Pneumonia? ❑ Yes ❑ No
   - f. Tuberculosis? ❑ Yes ❑ No
   - g. Silicosis? ❑ Yes ❑ No
   - h. Pneumothorax (collapsed lung)? ❑ Yes ❑ No
   - i. Lung cancer? ❑ Yes ❑ No
   - j. Broken ribs? ❑ Yes ❑ No
   - k. Any chest injuries or surgeries? ❑ Yes ❑ No
   - l. Any other lung problems that you've been told about? ❑ Yes ❑ No

4. Do you currently have any of the following symptoms of pulmonary or lung illness...
   - a. Shortness of breath? ❑ Yes ❑ No
   - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline? ❑ Yes ❑ No
   - c. Shortness of breath when walking with other people at an ordinary pace on level ground? ❑ Yes ❑ No
   - d. Have to stop for breath when walking at your own pace on level ground? ❑ Yes ❑ No
   - e. Shortness of breath when washing or dressing yourself? ❑ Yes ❑ No
   - f. Shortness of breath that interferes with your job? ❑ Yes ❑ No
   - g. Coughing that produces phlegm (thick sputum)? ❑ Yes ❑ No
   - h. Coughing that wakes you early in the morning? ❑ Yes ❑ No
   - i. Coughing that occurs mostly when you are lying down? ❑ Yes ❑ No
   - j. Coughing up blood in the last month? ❑ Yes ❑ No
   - k. Wheezing? ❑ Yes ❑ No
   - l. Wheezing that interferes with your job? ❑ Yes ❑ No
   - m. Chest pain when you breathe deeply? ❑ Yes ❑ No
   - n. Any other symptoms that you think may be related to lung problems? ❑ Yes ❑ No

5. Have you ever had any of the following cardiovascular or heart problems...
   - a. Heart attack? ❑ Yes ❑ No
   - b. Stroke? ❑ Yes ❑ No
   - c. Angina? ❑ Yes ❑ No
   - d. Heart Failure? ❑ Yes ❑ No
   - e. Swelling in your legs or feet (not caused by walking)? ❑ Yes ❑ No
   - f. Heart arrhythmia (heart beating irregularly)? ❑ Yes ❑ No
   - g. High blood pressure? ❑ Yes ❑ No
   - h. Any other heart problem that you've been told about? ❑ Yes ❑ No

6. Have you ever had any of the following cardiovascular or heart symptoms...
   - a. Frequent pain or tightness in your chest? ❑ Yes ❑ No
   - b. Pain or tightness in your chest during physical activity? ❑ Yes ❑ No
   - c. Pain or tightness in your chest that interferes with your job? ❑ Yes ❑ No

Employee Initials: ______

d. In the past two years, have you noticed your heart skipping or missing a beat? .... ❑ Yes ❑ No
e. Heartburn or indigestion that is not related to eating?... ❑ Yes ❑ No
f. Any other symptoms that you think may be related to heart or circulation problems? .... ❑ Yes ❑ No

7. Do you currently take medication for any of the following problems...
a. Breathing or lung problems? .... ❑ Yes ❑ No
b. Heart trouble? .... ❑ Yes ❑ No
c. Blood pressure? .... ❑ Yes ❑ No
d. Seizures (fits)? .... ❑ Yes ❑ No

8. If you have used a respirator, have you ever had any of the following problems...
(If you've never used a respirator, check this box and proceed to question 9)... 0
a. Eye irritation? .... ❑ Yes ❑ No
b. Skin allergies or rashes? .... ❑ Yes ❑ No
c. Anxiety? .... ❑ Yes ❑ No
d. General weakness or fatigue? .... ❑ Yes ❑ No
e. Any other problem that interferes with your use of a respirator? .... ❑ Yes ❑ No

9. **Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire**... ❑ Yes ❑ No

Part A, Section 2 - Mandatory

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you ever lost vision in either eye (temporarily or permanently)?.. ❑ Yes ❑ No

11. Do you currently have any of the following vision problems...
a. Wear contact lenses? .... ❑ Yes ❑ No
b. Wear glasses? .... ❑ Yes ❑ No
c. Color blind? .... ❑ Yes ❑ No
d. Any other eye or vision problem? .... ❑ Yes ❑ No

12. Have you ever had an injury to your ears, including a broken eardrum? .... ❑ Yes ❑ No

13. Do you currently have any of the following hearing problems...
a. Difficulty hearing? .... ❑ Yes ❑ No
b. Wear a hearing aid? .... ❑ Yes ❑ No
c. Any other hearing or ear problem?.. ❑ Yes ❑ No

14. Have you ever had a back injury?... ❑ Yes ❑ No

15. Do you currently have any of the following musculoskeletal problems…
a. Weakness in any of your arms, hands, legs, or feet? .... ❑ Yes ❑ No
b. Back pain? .... ❑ Yes ❑ No
c. Difficulty fully moving your arms and legs? .... ❑ Yes ❑ No
d. Pain or stiffness when you lean forward or backward at the waist? .... ❑ Yes ❑ No
e. Difficulty fully moving your head up or down? .... ❑ Yes ❑ No
f. Difficulty fully moving your head side to side? .... ❑ Yes ❑ No
g. Difficulty bending at your knees? .... ❑ Yes ❑ No
h. Difficulty squatting to the ground? .... ❑ Yes ❑ No
i. Climbing a flight of stairs or a ladder carrying more than 25 pounds? .... ❑ Yes ❑ No
j. Any other muscle or skeletal problem that interferes with using a respirator?............................ ❑ Yes ❑ No

Employee Initials: ______

The information provided in this questionnaire is true and correct to the best of my knowledge.

Employee Signature: ______________________________ **Date:** ________________

Licensed Health Care Professional's Evaluation

COMMENTS:

Reviewed by:
Licensed Health Care Professional: ________________________ **Date:**__________**Time:**________

Part B -Optional

Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amount of oxygen? .... ❑ Yes ❑ No

   a. If Yes, do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions?........................ ❑ Yes ❑ No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals?........................ ❑ Yes ❑ No

   a. If "Yes", name the chemicals if you know them: ______________________________

3. Have you ever worked with any of the materials, or under any of the conditions, listed below...
   a. Asbestos?........................ ❑ Yes ❑ No
   b. Silica (e.g., in sandblasting)? .... ❑ Yes ❑ No
   c. Tungsten/cobalt (e.g., grinding or welding this material)?........................ ❑ Yes ❑ No
   d. Beryllium?........................ ❑ Yes ❑ No
   e. Aluminum? .... ❑ Yes ❑ No
   f. Coal (for example, mining)? .... ❑ Yes ❑ No
   g. Iron?........................ ❑ Yes ❑ No
   h. Tin? .... ❑ Yes ❑ No
   i. Dusty environments?........................ ❑ Yes ❑ No
   j. Any other hazardous exposures?........................ ❑ Yes ❑ No
   k. If "Yes", describe these exposures:______________________________

4. List any second jobs or side businesses you have: ______________________________

   ____

Employee Initials: ______

5. List your previous occupations: ____

____

6. List your current and previous hobbies: ____

____

7. Have you been in the military services? ❑ Yes ❑ No

   a. If "Yes", were you exposed to biological or chemical agents (either in training or combat)? ❑ Yes ❑ No

8. Have you ever worked on a HAZMAT team? ❑ Yes ❑ No

10. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? ❑ Yes ❑ No

   a. If "Yes", name the medications if you know them: ______________________________

10. Will you be using any of the following items with your respirator(s):
   a. HEPA filters? ❑ Yes ❑ No
   b. Canisters (for example, gas masks)? ❑ Yes ❑ No
   c. Cartridges? ❑ Yes ❑ No

11. How often are you expected to use the respirator(s): (mark "Yes" or "No" for all answers that apply to you)?

   a. Escape only (no rescue)? ❑ Yes ❑ No
   b. Emergency rescue only? ❑ Yes ❑ No
   c. Less than 5 hours per week? ❑ Yes ❑ No
   d. Less than 2 hours per day? ❑ Yes ❑ No
   e. 2 to 4 hours per day? ❑ Yes ❑ No
   f. Over 4 hours per day? ❑ Yes ❑ No

12. During the period you are using the respirator(s), is your work effort:
   a. Light (less than 200 kcal per hour)? ❑ Yes ❑ No
   (Examples of a light work effort are sitting while writing, typing, drafting, or performing light assembly work; or standing while operating a drill press (1-3 lbs.) or controlling machines.)

   If "Yes", how long does this period last during the average shift:____________hrs.___________min

   b. Moderate (200 to 350 kcal per hour? ❑ Yes ❑ No
   (Examples of moderate work effort are sitting while nailing or filing; driving a truck or bus in urban traffic; standing while drilling, nailing, performing assembly work, or transferring a moderate (about 35 lbs.) at trunk level; walking on a level surface about 2 mph or down a 5-degree grade about 3 mph; or pushing a wheelbarrow with a heavy load (about 50 lbs.)).

   If "Yes", how long does this period last during the average shift:_____________hrs.___________mins.

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? ❑ Yes ❑ No

   a. If "Yes", Describe this protective clothing and/or equipment: ______________________________

14. Will you be working under hot conditions (Temperature exceeding 77oF)? ❑ Yes ❑ No

15. Will you be working under humid conditions? ❑ Yes ❑ No

16. Describe the work you'll be doing while you're using your respirator(s): ______________________________

____

Employee Initials: ______

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined, spaces, life-threatening gases):

____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

a. Name of the first toxic substance: ______________________
b. Estimated maximum exposure level per shift: ______________________
c. Duration of exposure per shift: ______________________
d. Name of the second toxic substance: ______________________
e. Estimated maximum exposure level per shift: ______________________
f. Duration of exposure per shift: ______________________
g. Name of the third toxic substance: ______________________
h. Estimated maximum exposure level per shift: ______________________
i. Duration of exposure per shift: ______________________
j. The name of any other toxic substances that you'll be exposed to while using your respirator: ____________

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for examples, rescue, security):

____

Employee Initials: ______