EASTERNMED

Your Health And Safety Source

PATIENT NAME_____ **DATE** _____

PATIENT ADDRESS_____ **CITY** **ZIP CODE**

DOB_____ **PHONE**

EMPLOYER NAME_____

MEDICAL SURVEILLANCE

19A PHYSICAL
DOT PHYSICAL
FIRE DEPT PHYSICAL
PHYSICAL
POLICE/ROAD PATROL PHYSICAL
MASK FIT/CLEARANCE
RESPIRATOR WRITTEN OPINION
SCBA FIT TEST
AUDIOGRAM
PFT
EKG
VISUAL ACUITY
PULSE OXIMETRY
ASBESTOS
HAZMAT

WORKERS COMPENSATION

TESTING

BLOOD COLLECTION
HAIR/FINGERNAIL
BREATH ETOH
DOT/NIDA COLLECT & TEST
SAP5 COLLECT & TEST
SAP 10 COLLECT & TEST

IMMUNIZATIONS

TETANUS
PPD
HEP B #_____
HEP A
MMR
FLU/PNEUMONIA

LABORATORY

CBC
CHOLESTEROL
HEPATITIS SCREEN
HIV SCREEN
LIPID PANEL
MMR TITER
GLUCOMETER FINGER STICK
HEP B TITER
ZPP
SERUM LEAD
CHEST X RAY 1 VIEW
URINALYSIS
PSA
OTHER _____

NEW PATIENT

99201 E/M LEVEL 1
99202 E/M LEVEL 2
99203 E/M LEVEL 3
99204 E/M LEVEL 4
99205 E/M LEVEL5

ESTABLISHED PATIENT

99211 E/M LEVEL 1
99212 E/M LEVEL 2
99213 E/M LEVEL 3
99214 E/M LEVEL 4
99215 E/M LEVEL 5

DIAGNOSIS

INTERNAL NOTES:_____

_____

_____

_____

_____

_____

SIGNATURE – MEDICAL PROVIDER

EASTERN MED, LLC.
5010 State Highway, 30 STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518)684-0156
WWW.EASTERNMEDICALSUPPORT.COM

EASTERNMED

Your Health And Safety Source

CONSENT FOR TREATMENT & RELEASE OF INFORMATION

I consent to receiving treatment and/or a physical examination to be performed by the physician, nurse practitioner and/or professional staff at the Occupational Health Center. I permit the physician, nurse practitioner, and or staff of Eastern Med, LLC to treat me in ways they judge beneficial to me or have been requested by my employer or prospective employer. I understand that this care may include tests, physical examinations, immunizations and the drawing of my blood.

I further consent that the medical information and results of such test or treatment that is related to my job / job functions may be released to the guarantor (Example: The company authorizing and paying for the medical services or their agents).

PERMISSION TO CONTACT YOUR MEDICAL PROVIDER(S)
&
PRIVACY STATEMENT / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

During the completion of your medical exam, significant findings may be identified which could have an impact on the performance of your work related duties. Further information from your medical provider(s) may be necessary to clear you for the employment or volunteer position you currently seek.

Please sign below if you agree to allow us to contact your medical provider(s) regarding significant medical findings, and / or additional information to clear you for your duties.

Furthermore, you also acknowledge that you have read and understand Eastern Med's HIPAA policy regarding the use of disclosure of protected health information, which is made in accordance with Federal Law (electronic version is available at www.easternmedicalsupport.com/resources.php).

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

The patient is unable to give consent because: _____

Signature: _____ Date: _____

Relationship: _____

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

EASTERNMED
Your Health And Safety Source

Medical History

Name: _____ Sex: _____ Date of Birth: _____

Address: _____

Phone: _____

Have you ever had, or do you now have any of the following? Check Yes or No, indicate age:

	Yes	No	Age
Surgery/Severe Injury			
Cancer/Tumor/Cyst			
Anemia/ Blood Disease			
Diabetes			
High Blood Pressure			
Thyroid Issues			
Skin Issues			
Ear/Nose/Throat Issues			
Eye Issues			
Lung Issues			
Heart Conditions			
Chicken Pox			
MMR			
Rheumatic/Scarlet Fever			
Phlebitis/ Blood Clot			

	Yes	No	Age
Abdominal/Ulcer Issues			
Kidney Disease/Stones			
Bladder/Prostate Issues			
Hernia (Rupture)			
Hemmorrhoids			
Varicose Veins			
Hand/Wrist/Arm Issues			
Foot/Ankle/Leg Issues			
Head/Neck/Spine Issues			
Back/Spine Pain			
Neurological Conditions			
Emotional Conditions			
Neuritis/Pinched Nerves			
Broken Bones			
Other			

If Yes, please explain: _____

_____

_____

_____

Date of last tetanus shot: _____ Date of last Tuberculosis (TB) test: _____

Do you take medications? ____ Yes ____ No If Yes, please list them: _____

_____

_____

Are you allergic to any medications? ___Yes ___No If yes, to what? _____

_____

Allergies other than medications: _____

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPDRT.CDM

Do you currently smoke? ___Yes ___No If yes, # of cigarettes per day: ____ # of years: ____

If no, did you previously smoke? ___Yes ___ No If yes, # of cigarettes per day: ____ #of years: ____

Do you drink alcoholic beverages? ___Yes ___No If yes, how much? _____

Have you used illegal drugs in the past 2 years? ___Yes ___No

Do you now, or have you ever, belonged to a substance abuse support group? ___Yes ___No

Do you, or have you, lived next door to or very near an industrial plant? ___Yes ___No

Do you have a hobby or craft which you do at home? ___Yes ___No

Do you use pesticides around your home or garden? ___Yes ___ No

---

Occupational History

Company: _____

Job: _____

Please List most recent job first, and then work backwards in time:

Approximate Dates	Employer Name and Location	Known Health Hazard Exposure

1. Have you ever been rejected or uprated for insurance because of your health? ___Yes ___No
2. Have you been rejected from employment, or the Armed Forces, because of health? ___Yes ___No
3. Has your work ever been limited or restricted because of health? ___Yes ___No
4. Have you ever filed a Workers Compensation claim? ___Yes ___No
5. Have you ever received benefits from a Workers Compensation claim? ___Yes ___No
6. Have you lost more than five consecutive days from work, in the past three years, because of illness or injury? ___Yes ___No
7. Do you have a condition requiring a special work assignment or work aids? ___Yes ___No
8. Have you developed hearing problems from noise exposure? ___Yes ___No
9. Have you had problems due to work with vibrating tools? ___Yes ___No

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

10. Have you had occupational radiation exposure? ___Yes ___No

11. Have you had problems because of exposure to solvents, fumes, chemicals, dust, or latex? ___Yes ___No

12. Have you had problems with any occupational materials irritating to you? ___Yes ___No

If Yes, please explain: _____

_____

_____

_____

_____

To the best of my knowledge, I certify that the above answers are true and complete.

Signature: _____ Date: _____

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

EASTERNMED
Your Health And Safety Source

JOB: _____

EMPLOYER: _____

PHYSICAL EXAMINATION:

NAME: _____ **DATE**: _____

DATE OF BIRTH: _____

VITAL SIGNS: HGT: _____ WT: _____ B/P: _____ PULSE: _____ TEMP: _____

URINALYSIS: PROTEIN: _____ GLUCOSE: _____ OTHER: _____

VISION: **WITHOUT GLASSES** BOTH: 20/_____ RIGHT 20/_____ LEFT: 20/_____ **WITH GLASSES/CONTACTS** BOTH: 20/_____ RIGHT: 20/ _____ LEFT: 20/_____

NORMAL TO TRAFFIC SIGNAL COLORS (Circle one)**: YES or NO**

COLOR BLIND (ISHIHARA): PLATE 1 2 3 4 5 6 7 8 9 10 11 12 13 14

NORMAL _____

ABNORMAL _____

HEARING:	**500 Hz**	**1000 Hz**	**2000Hz**	**4000Hz**
RIGHT:	20 25 40	20 25 40	20 25 40	20 25 40
LEFT:	20 25 40	20 25 40	20 25 40	20 25 40

WHISPER TEST: AD_____ AS_____

NORMAL TO CONVERSATION: (Circle one)**: YES or NO**

General Appearance:	Normal	**Mental Status**:	Normal
Skin:	Normal	**Abd**:	Normal
HEENT:	Normal	**Ing/Hernia**:	Normal
Neck:	Normal	**Exts**:	Normal
Thorax:	Normal	**Neuro**:	Normal
Heart:	Normal	**Reflexes**:	Normal

COMMENTS/ SUMMARY:

_____

_____

_____

_____

_____

Signature of Medical Provider: _____

Printed Name of Medical Provider: _____

Eastern Med, LLC.
5010 State Highway 30, Ste. 101
Amsterdam, NY 12010
Ph: (518) 843-6860
Fx: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

Silica Respirator Questionnaire

EASTERNMED
Your Health And Safety Source

Patient name:_____ **Date of Birth:** _____

Employer:_____

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination. However, certain responses, or patterns of response, may lead the reviewer to request further information, or a medical examination, in order to reach a conclusion regarding the employee's ability to safely use a respirator.

To the employee, Patient ID: _____ 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 or send this questionnaire to the health care professional who will review it.

Can you read? ☐ Yes ☐ No

Part A. Section 1. (Mandatory)

Every employee who has been selected to use any type of respirator must provide the following information.

1. Sex: ☐ Male ☐ Female
2. Your height: _____ft. _____in.
3. Your weight: _____lbs.
4. Your job title:_____
5. A phone number where you can be reached by the health care professional who reviews this questionnaire (include area code):
(_____) _____ - _____
6. The best time to call you at this number: _____ a.m./p.m.
7. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐ Yes ☐ No
8. Check box(es) of 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).
9. Have you worn a respirator? ☐ Yes ☐ No
   If "yes" what type(s)?

_____

_____

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

Patient name:_____ Date of Birth: _____

Part A. Section 2. (Mandatory)

Every employee who has been selected to use **any** type of respirator must answer questions 1 through 9 below.

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

2. Have you ever had any of the following conditions?
   - ☐ Seizures (fits)
   - ☐ Diabetes (sugar disease)
   - ☐ Allergic reactions that interfere with your breathing
   - ☐ Claustrophobia (fear of closed-in places)
   - ☐ Trouble smelling odors

3. Have you ever had any of the following pulmonary or lung problems?
   - ☐ Asbestosis
   - ☐ Asthma
   - ☐ Chronic bronchitis
   - ☐ Emphysema
   - ☐ Pneumonia
   - ☐ Tuberculosis
   - ☐ Silicosis
   - ☐ Pneumothorax (collapsed lung)
   - ☐ Lung cancer
   - ☐ Broken ribs
   - ☐ Any chest injuries or surgeries
   - ☐ Any other lung problem that you've been told about

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
   - ☐ Shortness of breath
   - ☐ Shortness of breath when walking fast on level ground or walking up a slight hill or incline
   - ☐ Shortness of breath when walking with other people at an ordinary pace or level ground
   - ☐ Have to stop for breath when walking at your own pace on level ground
   - ☐ Shortness of breath when washing or dressing yourself
   - ☐ Shortness of breath that interferes with your job
   - ☐ Coughing that produces phlegm (thick sputum)
   - ☐ Coughing that wakes you early in the morning
   - ☐ Coughing that occurs mostly when you are lying down
   - ☐ Coughing up blood in the last month
   - ☐ Wheezing
   - ☐ Wheezing that interferes with your job
   - ☐ Chest pain when you breathe deeply
   - ☐ Any other symptoms that you think may be related to lung problems

5. Have you ever had any of the following cardiovascular or heart problems?
   - ☐ Heart attack
   - ☐ Stroke
   - ☐ Angina
   - ☐ Heart failure
   - ☐ Swelling in your legs or feet (not caused by walking)
   - ☐ Heart arrhythmia (heart beating irregularly)
   - ☐ High blood pressure
   - ☐ Any other heart problem that you've been told about

6. Have you ever had any of the following cardiovascular or heart problems?
   - ☐ Frequent pain or tightness in your chest
   - ☐ Pain or tightness in your chest during physical activity
   - ☐ Pain or tightness in your chest that interferes with your job
   - ☐ In the past two years, have you noticed your heart skipping or missing a beat
   - ☐ Heartburn or indigestion that is not related to eating
   - ☐ Any other symptoms that you think may be related to heart or circulation problems

7. Do you currently take medication for any of the following problems?
   - ☐ Breathing or lung problems
   - ☐ Heart trouble
   - ☐ Blood pressure
   - ☐ Seizures (fits)

Patient name:_____ Date of Birth: _____

8. If you've used a respirator, have you ever had any of the following problems?
   - ☐ Eye irritation
   - ☐ Skin allergies or rashes
   - ☐ Anxiety
   - ☐ General weakness or fatigue
   - ☐ Any other problem that interferes with your use of a respirator
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? ☐ Yes ☐ No

Questions 10 to 15 must be answered by every employee who has been selected to use either a full-face piece 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?
    - ☐ Wear contact lenses
    - ☐ Wear glasses
    - ☐ Color blind
    - ☐ Any other eye or vision problem
12. Have you ever had an injury to your ears, including a broken ear drum? ☐ Yes ☐ No
13. Do you currently have any of the following hearing problems?
    - ☐ Difficulty hearing
    - ☐ Wear a hearing aid
    - ☐ Any other hearing or ear problem
14. Have you ever had a back injury?
15. Do you currently have any of the following musculoskeletal problems?
    - ☐ Weakness in any of your arms, hands, legs or feet
    - ☐ Back pain
    - ☐ Difficulty fully moving your arms and legs
    - ☐ Pain or stiffness when you lean forward or backward at the waist
    - ☐ Difficulty fully moving your head up or down
    - ☐ Difficulty fully moving your head side to side
    - ☐ Difficulty bending at your knees
    - ☐ Difficulty squatting to the ground
    - ☐ Climbing a flight of stairs or a ladder carrying more than 25 lbs
    - ☐ Any other muscle or skeletal problem that interferes with using a respirator

---

Respirator Physical Exam:

Urinalysis (*Protein*): _____ **Pulse Oximetry:** _____

HEIGHT:	WEIGHT:	PULSE:	BLOOD PRESSURE (sitting):

Physical Exam	N	Ab	Physical Exam (cont.)	N	Ab
1. Eyes			7. Neck		
2. Nose			8. Lung		
3. Oropharynx			9. Heart		
4. Teeth			10. Extremities		
5. Outer Ear			11. TM's		
6. Beard/Mustache			12. Other_____		

Comments: _____

_____

_____

EASTERNMED
Your Health And Safety Source

Initial/Periodic Silica Exam Questionnaire

1. Have you worn protective equipment (clothes, safety glasses, respirator, hearing protection)? ☐ Yes ☐ No
2. Have you participated in workplace medical monitoring (blood, urine, chest x-ray, respirator program? ☐ Yes ☐ No

Have you ever experienced any of the following symptoms or conditions due to workplace exposure?

1. Severe allergic reaction, difficulty breathing or swallowing ☐ Yes ☐ No
2. Heart pain, palpitations, heart muscle damage ☐ Yes ☐ No
3. Cough, shortness of breath, wheezing, asthma, lung damage, abnormal breathing tests or chest x-ray ☐ Yes ☐ No
4. Dizziness, fainting, blackouts, seizure, headaches, fatigue ☐ Yes ☐ No
5. Arm or leg weakness, numbness, pins/needles sensation ☐ Yes ☐ No
6. Abnormal liver blood tests, liver damage, hepatitis, weight loss, jaundice ☐ Yes ☐ No
7. Abdominal pain, stomach or intestinal problems, weight loss, blood in stool Yes ☐ No
8. Abnormal kidney blood or urine tests, kidney damage ☐ Yes ☐ No
9. Rash, skin cancer ☐ Yes ☐ No
10. Abnormal blood counts, anemia, swollen glands ☐ Yes ☐ No
11. Heat, cold illness, burns, frostbite ☐ Yes ☐ No
12. Difficulty with mood, memory, concentration ☐ Yes ☐ No

Have or have had any of the following medical conditions?

1. Hay fever, allergic rhinitis ☐ Yes ☐ No
2. Asthma, chronic bronchitis, COPD ☐ Yes ☐ No
3. Heart disease, congestive heart failure, hypertension, atrial fibrillation ☐ Yes ☐ No
4. Ulcers, Crohn's disease, diverticulitis ☐ Yes ☐ No
5. Hepatitis, cirrhosis, liver disease, gallbladder disease ☐ Yes ☐ No
6. Stroke, seizures, depression, anxiety, dementia, Parkinson's disease, multiple sclerosis ☐ Yes ☐ No
7. Leukemia, lymphoma, cancer ☐ Yes ☐ No
8. Another chronic/serious health condition ☐ Yes ☐ No
9. Any disability, physical limitation ☐ Yes ☐ No
10. Have you had any type of surgery ☐ Yes ☐ No
11. In previous jobs, did you have any occupational exposure to respirable silica: ☐ Yes ☐ No
If yes, what was your job? _____

12. What is your current level of occupational exposure to respirable silica? _____

13. What is your current job? _____

14. What is your anticipated level of future occupational exposure to respirable silica? _____

15. Describe any personal protective equipment currently used, or to be used, to protect against respirable silica exposure:

_____

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

Initial/Periodic Silica Exam Questionnaire

EASTERNMED
Your Health And Safety Source

Have/had any of the following musculoskeletal conditions:

1. Back injury, strain, herniated disc, recurring ache ☐ Yes ☐ No
2. Neck problems, neck pain, whiplash ☐ Yes ☐ No
3. Bursitis, tendonitis ☐ Yes ☐ No
4. Foot or ankle problems ☐ Yes ☐ No
5. Fractures ☐ Yes ☐ No
6. Hand, wrist, elbow problem ☐ Yes ☐ No
7. Knee or shoulder problems ☐ Yes ☐ No

What year was your last diphtheria/tetanus booster? _____

Have you completed the series of three Hepatitis B injections? ☐ Yes ☐ No

List all medications you are currently taking: _____

_____

_____

Previous Employment

Employer	Job Title	Dates Employed

Provider notes:

_____
_____
_____
_____
_____

Exposure history

Please **DESCRIBE** any of the following exposures that may have occurred in the course of previous or current employment, or as a result of ongoing hobbies:

Asphalt Roofing Materials _____
Concrete Products/Cement _____
Porcelain Enameling _____
Dental Lab _____
Foundries _____
Production or use of Silica Flour _____
Glass Manufacturing _____
Support for Gas/Oil Operations _____
Surface Coal Mining _____
Tunneling _____
Structural Clay Products _____
Hard-rock Mining _____
Masonry _____
Blast Furnaces _____
Steel Works _____
Rolling and Finishing Mills _____
Jewelry Making _____
Pottery Ceramic _____
Railroads _____
Underground Coal Mining _____
Shipyards _____
Hydraulic Fracturing of Gas/Oil Wells _____
Fabrication & Installation of Engineered Stone Counter-top _____
Sand Blasting (Including Denim Sandblasting) _____

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

Tuberculosis History Questionnaire

EASTERNMED
Your Health And Safety Source

Patient Name: _____ **Date:** _____

Date of Birth: _____

Early Detection of Tuberculosis

This questionnaire gives guidance in identifying individuals with suspected or confirmed TB so that the appropriate controls can be promptly initiated.

Complete the questions in parts 1-3. Please answer these questions to the best of your knowledge.

TB History (Part 1)

1. Have you ever had a positive TB Skin Test? ☐ Yes ☐ No ☐ Don't know
2. Have you ever had an abnormal Chest X-ray? ☐ Yes ☐ No ☐ Don't know
3. Have you recently had the mucus you cough up tested for TB? ☐ Yes ☐ No ☐ Don't know
   - If yes, were you told it was positive? ☐ Yes ☐ No ☐ Don't know
4. Have you ever been told you have Infectious Tuberculosis? ☐ Yes ☐ No ☐ Don't know
   - If yes, how long ago? _____
5. Have you ever been treated with medication for Infectious TB? ☐ Yes ☐ No ☐ Don't know
   - If yes, how many medications? (check one) ☐ 1 ☐ 2 ☐ 2+
   - Are you still taking TB medicine? ☐ Yes ☐ No
   - Did you take all the medicine until the health care professional said you were done? ☐ Yes ☐ No
6. Do you live with/have you been in close contact with someone who was recently diagnosed with TB? ☐ Yes ☐ No ☐ Don't know

Current Symptoms (Part 2)

1. Do you have a cough that has lasted longer than three weeks? ☐ Yes ☐ No
2. Do you cough up blood or mucus? ☐ Yes ☐ No
3. Have you lost your appetite? Aren't hungry? ☐ Yes ☐ No
4. Have you lost weight (more than 10 lbs) in the last two months without trying to? ☐ Yes ☐ No
5. Do you have night sweats (need to change bedclothes because they are wet)? ☐ Yes ☐ No
6. Do you have any of the following: ☐ fatigue ☐ fever ☐ chills ☐ chest pain
   If yes, please explain: _____

Mantoux Step 1 Current Patient Status (Part 3)

Are you currently taking any medications? ☐ Yes ☐ No
- If yes, list here _____

Are you currently pregnant? ☐ Yes ☐ No

Employee/Applicant signature: _____ Date: ____ / ____ / ____
Month / Day / Year

ANSWER THE BELOW QUESTIONS AT THE TIME OF YOUR 2ND MANTOUX TEST (If Step 2 is required)

Mantoux Step 2 Current Patient Status

Are you currently taking any medications? ☐ Yes ☐ No
- If yes, list here _____

Are you currently pregnant? ☐ Yes ☐ No

Employee/Applicant signature: _____ Date: ____ / ____ / ____
Month / Day / Year

Evaluator comments: _____

Chest X-ray preliminary reading: ☐ Negative ☐ Positive ☐ Undetermined

☐ Person meets criteria and should be treated for latent TB ☐ Person shows no signs or symptoms of active TB

Physician signature: _____ Date: ____ / ____ / ____

Tuberculosis Testing Documentation

EASTERNMED
Your Health And Safety Source

Patient information:

Patient Name: _____ **Date:** _____

Date of Birth: _____

EMPLOYEE TO FILL OUT

1. Have you ever had a previous Mantoux test? ☐ Yes ☐ No If Yes, when? _____
2. What were the results? ☐ Positive ☐ Negative
3. Were you ever treated for TB? ☐ Yes ☐ No If Yes, when? _____

Employee/Applicant signature: _____ Date: Month ____ / Day ____ / Year ____

NURSE/MA TO FILL OUT

Employee receiving:

☐ TB History Questionnaire ☐ 2-Step Mantoux (baseline) ☐ 1-Step Mantoux (annual) ☐ Quantiferon

2-Step TST Administration

#1 Date:	Time:	Lot: Exp:	Location:	Given By:
#2 Date:	Time:	Lot: Exp:	Location:	Given By:

TST Reading

Date:	Time:	Result (mm)	Read by:
Date:	Time:	Result (mm)	Read by:

QUANTIFERON TB Blood Test

Name of TB blood test	Quantiferon TB Test
Date of blood draw	
RESULTS	
Interpretation of reading	☐ Positive ☐ Negative ☐ Indeterminate
Laboratory	

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

EASTERNMED
Your Health And Safety Source

AUTHORIZATION FOR CRYSTALLINE SILICA OPINION TO EMPLOYER

This medical examination for exposure to crystalline silica could reveal a medical condition that results in recommendations for (I) limitations on respirator use, (2) limitations on exposure to crystalline silica, or (3) examination by a specialist in pulmonary disease or occupational medicine. Recommended limitations on respirator use will be included in the written opinion to the employer. If you want your employer to know about limitations on crystalline silica exposure or recommendations for a specialist examination, you will need to give authorization for the written opinion to the employer to include one or both of those recommendations.

I hereby authorize the opinion to the employer to contain the following information, if relevant (please check all that apply):

O Recommendations for limitations on crystalline silica exposure

O Recommendation for a specialist examination

OR

D I do not authorize the opinion to the employer to contain anything other than recommended limitations on respirator use.

Please read and initial:

I understand that if I do not authorize my employer to receive the recommendation for specialist examination, the employer will not be responsible for arranging and covering costs of a specialist examination.

_____
Name (printed)

_____ _____
Signature Date

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

EASTERNMED
Your Health And Safety Source

Written Medical Opinion for Employer

EMPLOYER: ----------

EMPLOYEE NAME: _____ **DATE OF EXAMINATION:** _____

TYPE OF EXAMINATION:
[ ] Initial examination [ ] Periodic examination [ ] Specialist examination
[ ] Other: ----------

USE OF RESPIRATOR:
[ ] No limitations on respirator use
[ ] Recommended limitations on use of respirator: _____

Dates for recommended limitations, if applicable: _____ to _____
MM/DD/YYYY MM/DD/YYYY

The employee has provided written authorization for disclosure of the following to the employer (if applicable):

[ ] I recommend that this employee should be examined by a Board Certified Specialist in Pulmonary Disease.
[ ] Recommended limitations on exposure to respirable crystalline silica:

_____

_____

Dates for exposure limitations noted above: _____ to _____
MM/DD/YYYY MM/DD/YYYY

NEXT PERIODIC EVALUATION: [ ]3 years [ ] Other: _____
MM/DD/YYYY

Examining Provider: _____ Date: _____
(signature)
Provider Name: _____ Provider's specialty: _____

Office Address: _____ Office Phone: _____

[ ]I attest that the results have been explained to the employee.

The following is required to be checked by the Physician or other licensed Health Care Professional (PLHCP):
[ ]I attest that this medical examination has met the requirements of the medical surveillance section of the OSHA Respirable Crystalline Silica standard(§ 1910.1053(h) or 1926.1153(h)).

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

EASTERNMED
Your Health And Safety Source

WRITTEN MEDICAL REPORT FOR EMPLOYEE

EMPLOYEE NAME: _____ **DATE OF EXAMINATION:** _____

TYPE OF EXAMINATION:

[ ]Initial examination [ ] Periodic examination [ ] Specialist examination [ ] Other _____

RESULTS OF MEDICAL EXAMINATION:

Physical Examination-	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Chest X-Ray-	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Breathing Test (Spirometry)-	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Test for Tuberculosis-	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed
Other:_____	[ ] Normal	[ ] Abnormal (see below)	[ ] Not performed

Results reported as abnormal: _____

RECOMMENDATIONS:

[ ] No limitations on respirator use

[ ] Recommended limitations on use of respirator: _____

[ ] Recommended limitations on exposure to respirable crystalline silica: _____

Dates for recommended limitations, if applicable: _____ to _____
MM/DD/YYYY MM/DD/YYYY

[ ] **I recommend that this employee should be examined by a Board Certified Specialist in Pulmonary Disease.**

[ ] Other recommendations*:

_____

Your next periodic examination for silica exposure should be in: [ ] 3 years [ ] Other: _____
MM/DD/YYYY

Examining Provider: _____ Date: _____
(signature)

Provider Name: _____

Office Address: _____ Office Phone: _____

*These findings may not be related to respirable crystalline silica exposure or may not be work-related, and therefore may not be covered by the employer. These findings may necessitate follow-up and treatment by your personal physician.

Respirable Crystalline Silica standard(§ 1910.1053 or 1926.1153)

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

EASTERNMED
Your Health And Safety Source

RESPIRATOR CLEARANCE- EXAMINER'S WRITTEN OPINION

Employee Name: _____ Date _____

Job title: _____ Employer: _____

Based on review of the OSHA Respirator Health Questionnaire (CFR 1910.134), Interview, physical examination or further evaluation as appropriate, this individual is:

- *Medically approved for* all respirators with the exception of SCBA and subject to fit test.
- *Medically not approved* to wear any type of respirator.

BASED ON INTERVIEW, PHYSICAL EXAMINATION AND FURTHER EVALUATION AS APPROPRIATE, THIS INDIVIDUAL IS;

- Medically approved for all respirators including SCBA and subject to fit testing:
- Medically approved for only the following types subject to satisfactory fit testing: _____
- Dusk Mask
- Negative Pressure
- Powered air purifying respirator
- Supplied Air
- Self-contained breathing apparatus (SCBA)
- Employee may decline respirator required assignments for temporary health related difficulties
- Respirator assignment must not be for IDHL (Immediate Danger to Life and Health) environments
- Employee should not be expected to perform rescue duty or serve as a member of a rescue team
- Requires further medical information /evaluation prior to qualifying for respirator use.
- Other recommendations and suggested accommodations

Recommended time period for next exam: 1 YEAR

Notes (optional):

_____

The employee has been notified of the results of this evaluation, and has been provided a copy of this written recommendation.

_____

Medical Examiner's Signature

EASTERN MED, LLC.
5010 State Highway, 30, STE 101
Amsterdam, NY 12010
PH: (518) 843-6860
FAX: (518) 684-0156
WWW.EASTERNMEDICALSUPPORT.COM

EASTERNMED
Your Health And Safety Source

5010 State Highway 30, Ste 101
Amsterdam, NY 12010
Phone: 518.843.6860
Fax: 518.684.0156

Authorization for Release of Confidential Medical Information

Patient Name: _____ Date: _____

Address: _____

Phone: _____ Date of Birth: _____

I, the undersigned, hereby authorize and request **Eastern Med, LLC** to release all confidential medical information regarding my condition for the period of the time specified below. This authorization includes physical forms, progress notes, consultation, laboratory tests, x-ray reports, diagnostic studies, telephone messages, medication and health flow maintenance flow sheets, immunization records, and discharge summaries.

Disclosure information to:

_____
Employer / Facility / Physician Name

_____
Address / Phone number

_____
Reason for this release of information

_____
Nature of condition (be as specific as possible)

***Date of Service*:** **From**: _____ **To**: _____

I understand that I can decide to at any time to cancel this release in writing but, that letter will not apply to records already sent.

Time during which release is authorized (*Please check one*):

◯ ***1 year*** or
◯ From: _____ To: _____

_____ _____
Signature **Date**

_____
Relationship if other than patient

*Information Release **From** Eastern Med.*