

**MAINE OCCUPATIONAL DISEASE SURVEILLANCE FORM**

Please complete this form on all patients with a reportable occupational disease.  Return form to: Occupational Disease Registry Maine Center for Disease Control and Prevention Environmental and Occupational Health Programs 11 SHS, 286 Water Street, Key Bank Plaza, 3 <sup>rd</sup> Floor. Augusta, Maine 04333-0011  For any questions: (207) 287-5378 Fax (207) 287-3981 TTY: Relay 711	<b>CLINICIAN OR FACILITY</b>  Name: _____  Address: _____ _____  Phone# _____ Contract Person: _____
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PATIENT NAME (Last)	(First)	(Middle)	(Maiden or aliases)
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PATIENT'S ADDRESS AT DIAGNOSIS	(Street, City, State, Zip Code)
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RACE (Check one) <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Black <input type="checkbox"/> American Indian  <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other	Date of Birth (Month, Day, Yr)	Sex (Check one) <input type="checkbox"/> Male  <input type="checkbox"/> Female
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Does Patient Currently smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, how many pack(s) a day? _____
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Is there any reason we should not contact this patient directly? <input type="checkbox"/> Ok to contact patient  <input type="checkbox"/> Please do not contact the patient for the following reasons(s): _____	Patient's Telephone number (including area code)
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OCCUPATION/JOB TYPE  For fishers, please indicate the method of fishing employed, e.g. diving, trawling, digging, gillnetting, dredging, etc	INDUSTRY  For fishers, please indicate the type of fish caught or harvested, e.g., scallops, lobster, haddock, etc
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NAME OF EMPLOYER And ADDRESS
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TELEPHONE NUMBER OF EMPLOYER (including area code)
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<b>REPORTABLE DISEASE</b> Date of visit _____ <b>IF TEST TAKEN COLLECTION DATE</b> _____  Please check one of the following: <input type="checkbox"/> Work-Related <input type="checkbox"/> Not Work-Related <input type="checkbox"/> Suspect Work-Related <input type="checkbox"/> Unknown  <b>Check all that apply</b>  <input type="checkbox"/> Agriculturally – related injury (includes farming, logging, and fishing). Please describe how injury occurred, and the physical findings of the injury. _____ _____  <input type="checkbox"/> Asbestosis <input type="checkbox"/> Byssinosis <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Heavy Metal Poisoning <input type="checkbox"/> Arsenic (level) _____ <input type="checkbox"/> Cadmium (level) _____ <input type="checkbox"/> Lead (level) _____ <input type="checkbox"/> Mercury (level) _____ <input type="checkbox"/> Hypersensitivity Pneumonitis (caused by _____) <input type="checkbox"/> Mesothelioma <input type="checkbox"/> Occupational Asthma (caused by _____) <input type="checkbox"/> Outbreaks (agent _____) <input type="checkbox"/> Pesticide Poisoning (name of pesticide _____) <input type="checkbox"/> Silicosis <input type="checkbox"/> Solvent Toxicity (name of solvent _____) <input type="checkbox"/> Toxic Gas Poisoning ( <input type="checkbox"/> Ammonia <input type="checkbox"/> Chlorine <input type="checkbox"/> Hydrogen Sulfide ) <input type="checkbox"/> Other (please describe) _____
<b>Comments:</b>

COMPLETED BY	DATE:
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