NORTON OCCUPATIONAL MEDICINE

Norton Occupational Medicine 12903 Shelbyville Road Louisville KY 40203	Norton Occupational Medicine 438 Shepherdsville Pkwy #2 Shepherdsville KY 40165	Norton Occupational Medicine 3605 Northgate Court #110 New Albany IN 47150

CONSENT FOR SERVICES

Date: _____

Name: _____ **Social Security #**_____
First M.I. Last

Address: _____ **SEX**: Male Female

City _____ **State**_____ **Zip Code**_____

Home Phone: (**)** _____ **Cell: (** **)** _____

Work Phone: (**)** _____

Date of Birth: _____ **Age**:_____ **Email Address**: _____

Employer Name: _____ **Employer Phone**: ( )_____

Employer Contact _____ **Employer Address**: _____

City:_____ **State**:_____ **Zip Code**: _____

Optional: Injuries Only

Date and Time of Injury: _____ Injury Description: _____

VOLUNTARY CONSENT FOR SERVICES AND RELEASE OF INFORMATION

I voluntarily consent to care that may involve routine diagnostic tests, procedures, and/or medical treatment as prescribed by my physician and/or advance practice registered nurse and performed by employees of Norton Occupational Medicine. No guarantee has been given by anyone as to the results of the care to be provided. I also consent and agree to provide breath, blood, hair and/or urine sample(s) for the purposes of testing for the presence of alcohol and/or drugs. I authorize these samples to be sent out to the laboratory for analysis if needed.

I understand and acknowledge that I may require the services of physicians or other health care providers who are not employees of Norton Occupational Medicine, including, but not limited to, radiologists. I agree that Norton Healthcare is not responsible for and does not assume any liability for the activities of any such physicians or practitioners who are not its employees.

I authorize any treating physician/nurse practitioner and/or Norton Occupational Medicine to disclose to my employer, potential employer, or insurance carrier, as appropriate, any information regarding this treatment and/or related tests and services. I understand that any refusal to submit for testing, or refusal of certain tests, may subject me to adverse consequences with the requesting party and/or any applicable government agencies. I acknowledge that a copy of the Privacy Practices has been made available to me.

Date: _____ **Time**: _____

PATIENT SIGNATURE (***or*** *check below*) _____

( ) Parent ( ) Guardian ( ) Legally Authorized Representative

Witness: _____

Patient unable to consent because _____

( ) Interpreter services used during informed consent discussion - Interpreter Name and ID # _____

Norton Healthcare Telemedicine Informed Consent

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Norton Healthcare providing health care services to me via telemedicine. The information discussed may be used for diagnosis, therapy, follow-up and/or education.

Expected Benefits:

- Improved access to care by enabling a patient to obtain services from providers at distant sites.
- Patient remains closer to home where local healthcare providers can maintain continuity of care.
- Reduced need to travel for the patient or other provider.

The Process:

You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemedicine staff in the room with you, if you are unsure of what is happening. If you are not comfortable with seeing a provider on videoconferencing technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time. Safety measures have been implemented to ensure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible Risks:

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telehealth encounter is not yielding sufficient information to make an appropriate clinical decision.
- Technology problems may delay medical evaluation and treatment for your encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By Signing this Form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I also understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telemedicine visit and schedule a face-to-face visit.

4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent to the Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

I hereby authorize Norton Healthcare to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or Authorized Person) _____ Date _____

If Authorized Signer, relationship to patient _____

Witness _____ Date _____

NORTON
OCCUPATIONAL MEDICINE

EXAMINATION HISTORY

I. IDENTIFICATION:

Name:_____Social Security #: _____-_____-_____

Address:_____

Sex: ☐ Female ☐ Male Date of Birth: _____/_____/_____ Age:_____

Home phone number:_____ Work Phone Number:_____

Personal Physician:_____

Job position:_____

Type of examination: ☐ Pre-placement ☐ Periodic ☐ Return to Work ☐ DOT ☐ Other:_____

II. OCCUPATIONAL PROFILES:

Fill in the table below listing all jobs in the past 5 y ears which you have worked including short-term or part-time employment. Start with your present job and go back to the first.

Work place (employer name, address):	Dates worked (Approx. begin date/end date):	Did you work full time?	Type of industry (describe):	Describe your job dutes:	Know health hazards in the work place?	Protective equipment used?	Were you ever off work for a health problem or injury?

III. EXPOSURE HISTORY

Please describe any health problems or injuries you have experienced connected with your present or past jobs.

1. Have any of your co-workers experienced health problems or injuries connected with the same job? If yes, please describe: ☐Yes ☐No

   _____

2. Do you smoke cigarettes, cigars, or pipes? ☐Yes ☐No
   If so, which and how many per day?_____
   If you have quit, when?_____
3. Did you ever smoke? ☐Yes ☐No
   If so, how much and for how long?_____
4. Do you have any allergies or allergic conditions? ☐Yes ☐No
   If so, please describe:_____
5. Have you ever worked with any substance that cause you to break out in a rash? ☐Yes ☐No
   If so, please describe your reaction and the name of the substance that caused it:

   _____
6. Have you ever been off work for more than a day because of any illness or injury related to work? ☐Yes ☐No
   If so, please describe:_____
7. Have you ever worked at a job which caused you trouble breathing, such as a cough, shortness of breath, or wheezing? ☐Yes ☐No
   If so, please describe:_____
8. Have you ever changed jobs or worked assignments because of health problems or Injuries? ☐Yes ☐No
   If so, please describe:_____
9. Do you frequently experience pain in your lower back or have you been under a doctor's care for back problems? ☐Yes ☐No
   If so, please describe:_____

IV. PERSONAL MEDICAL HISTORY

1. Please list all medical illnesses which you have now or have had in the past:

   _____

   _____

2. Please list all operations you have had in the past and approximate dates:

   _____

   _____

3. Please list any serious injuries you have had in the past and approximate dates:

   _____

   _____

4. Please list any medications, both prescribed and over-the-counter, which you now use regularly or occasionally:

   _____

   _____

5. Have you noticed any unintentional change in your weight within the past 6 months? Yes No

6. Have you ever had any of the following illnesses:

Arthritis	Yes No	Kidney Disease	Yes No
Tuberculosis	Yes No	Hernia	Yes No
Thyroid	Yes No	Epilepsy or convulsion	Yes No
Measles	Yes No	Nervous disorders	Yes No
Mumps	Yes No	Cancer	Yes No
Stomach ulcer/intestinal disorders	Yes No	Fainting spells	Yes No
Pneumonia	Yes No	Hay fever	Yes No
Diabetes	Yes No	Skin disorders	Yes No
Venereal disease	Yes No	Liver disease	Yes No
Asthma	Yes No	Hepatitis	Yes No
High blood pressure	Yes No	Anemia	Yes No
Emphysema	Yes No	Mental disorders	Yes No
Addiction to drugs/alcohol	Yes No	Back problems	Yes No
Migraines	Yes No	Carpal tunnel	Yes No
Hemorrhoids	Yes No	Shoulder/elbow problems	Yes No

If you answered yes to any of the above, please explain:

_____

_____

_____

7. Do you drink alcohol? Yes No

If so, how much and how frequently? _____

8. Do you feel like you have ever had a problem with drugs? Yes No

If so, please describe: _____

I understand any incorrect or misleading statement may be grounds for dismissal. I understand that this assessment is to determine my capabilities and it is not intended to be a health evaluation for ony other purpose. I understand that my health is my personal responsibility and I will consult with my healthcare provider for health problems. I further understand and authorize that this health history and medical examination, as stated on this report and any attachments thereto, will be reported to my company's HR, Safety, or other authorized department. Work restrictions, if any, will also be shared with company managers at my assigned work site.

_____ _____

**Signature of applicant* *Date*

NORTON
OCCUPATIONAL
MEDICINE

SPIROMETRY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____

1. Have you smoked any cigarettes, pipes, or cigars within the last hour? Yes No

   If yes, how much? _____

2. Have you used any inhaled medications, such as aerosolized bronchodilators, within the last hour? Yes No

   If yes, please list the medication(s): _____

3. Have you eaten within the last hour? Yes No

4. Have you had any respiratory infection, such as flu, pneumonia, severe cold, or bronchitis within the last 3 weeks? Yes No

5. Have you had any ear infections or other ear problems within the last 3 weeks? Yes No

   If yes, please explain: _____

6. Have you had any recent surgeries (including Lasik eye surgery)? Yes No

   If yes, please explain: _____

7. If you wear dentures, are they lose? Yes No

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____

NORTON
OCCUPATIONAL
MEDICINE

OSHA Mandatory Respirator Medical Evaluation Questionnaire
29 CFR 1910.134

To the employer: Answers to question in Section 1 and to question 9 in Section 2 of Part A do not require a medical examination.

To the employee: Can you read? ❑ Yes ❑ No

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

Social Security Number _____-_____-_____

Part A. Section 1 (Mandatory)

Every employee who has been selected to use any type of respirator must provide the following information (please print):

Name:_____**Sex:** ❑ Male ❑ Female **Date:**_____/_____/_____

Date of Birth: _____/_____/_____**Height** _____ft. _____in. **Weight** _____lbs.

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone Number: (_____) _____-_____**Best Time to Call:**_____

Employer: _____ **Job Title:** _____

1. Has your employer told you how to contact the health care professional who will review this questionnaire?
❑ Yes ❑ No

2. Check the type of respirator you will use (you can check more than one category):
❑ N, R, or P disposable respiratory (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)

3. Have you ever worn a respirator before? ❑ Yes ❑ No If so, what type? _____

Part A. Section 2 (Mandatory)

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

5. Have you ever had any of the following conditions?
_____seizures _____diabetes _____allergic reactions that affect breathing
_____claustrophobia _____trouble smelling odors

6. Have you ever had any of the following pulmonary or lung problems?
_____asbestos _____asthma _____chronic bronchitis _____emphysema _____tuberculosis
_____silicosis _____pneumothorax (collapsed lung) _____lung cancer _____broken ribs
_____any chest injuries or surgeries _____pneumonia _____other lung problems, list:_____
_____

7. Do you currently have any of the following symptoms of pulmonary or lung illness?
_____shortness of breath
_____shortness of breath walking up a slight incline or hill
_____shortness of breath when washing or dressing yourself
_____coughing that produces phlegm (thick sputum)
_____coughing that occurs mostly when you are lying down
_____wheezing
_____chest pain when you breathe deeply
_____shortness of breath when walking on level ground
_____have to stop for breath when walking at your own pace on level ground
_____shortness of breath that interferes with your job
_____coughing that wakes you early in the morning
_____coughing up blood in the last month
_____wheezing that interferes with your job
_____other symptoms, list:_____
_____

8. Have you ever had any of the following cardiovascular or heart problems?

_____heart attack: year_____ _____stroke: year_____ _____angina
_____heart failure: year_____ _____swelling of your legs or feet (not caused by walking)
_____heart arrhythmia (heart beating irregularly) _____high blood pressure: list medication: _____
_____other heart problems, list: _____

9. Have you ever had any of the following cardiovascular or heart symptoms?

_____frequent pain or tightness in your chest _____pain or tightness during physical activity
_____pain or tightness in your chest that interferes with your job _____in the last two years have you noticed your heart skipping or missing a beat
_____heartburn or ingestion that is not directly related to eating _____other symptoms, list: _____
_____

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

10. Do you currently take medication for any of the following problems?

_____breathing or lung problems, list: _____
_____heart troubles, list: _____
_____blood pressure
_____seizures, list: _____

11. If you use a respirator, have you ever had any of the following problems?

_____eye irritation _____skin allergies or rashes _____anxiety _____general weakness or fatigue
_____other symptoms, list: _____

12. Do you want to speak to a healthcare professional regarding this questionaire? ❑ Yes ❑ No

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

14. Do you currently have any of the following vision problems?

_____wear glasses _____wear contact lens _____color blind _____other problems, list: _____
_____

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

16. Do you currently have any of the following hearing problems?

_____difficulty hearing _____wear hearing aid, list ear(s): _____
_____other hearing problems, list: _____

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

18. Do you have any of the following musculoskeletal problems?

_____weakness in any of your hands, arms, feet, or legs _____back pain (continuously)
_____back pain (only with activity) _____difficulty full moving your arms and legs
_____pain or stiffness when you learn forward or backward at the waist
_____difficulty fully moving your head up or down, side to side
_____difficulty bending at the knees _____difficulty squatting to the ground
_____difficulty climbing stairs with more than 25 lbs. _____difficulty climbing a ladder
_____difficulty climbing a ladder with more than 25 lbs. _____other problems, list: _____
_____

Part B. Any of the following questions, and other questions listed, may be added to the questionaire at the discretion of the health care professional who will review the questionaire.

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

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

20. 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

If yes, name the chemicals if you know them:_____

21. Will you use any of the following items with your respirator? ❑ HEPA filters ❑ canisters ❑ cartridges

22. How often are you expected to use the respirator?

_____only to escape in an emergency situation _____emergency rescue procedures _____less than 5 hours per week
_____less than 2 hours per day _____2 to 4 hours per day _____over 4 hours per day

23. During the period you are using the respirator(s), is your work effort:

Light (less 200 kcal per hour): ❑ Yes ❑ No
If yes, how long does this period last during the average shift? _____hrs._____mins.
Moderate (200 to 350 kcal per hour): ❑ Yes ❑ No
If yes, how long does this period last during the average shift? _____hrs._____mins.
Heavy (above 350 kcal per hour): ❑ Yes ❑ No
If yes, how long does this period last during the average shift? _____hrs._____mins.

Examples of heavy work are lifting a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; shoveling; standing while bricklaying or chipping castings; walking up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

24. Have you ever been in the military service? ❑ Yes ❑ No
If yes, were you ever exposed to biological or chemical agents in the service? ❑ Yes ❑ No

25. Have you ever been a member of a HAZMAT team? ❑ Yes ❑ No

26. At work or home have you ever been exposed to hazardous solvents or hazardous airborne chemicals that have caused you to miss work time? ❑ Yes ❑ No

27. List any second jobs that you currently hold:_____

28. List your previous occupation:_____

29. List your current and previous hobbies:
_____

30. Describe the type of work you will be doing while wearing the respirator:
_____
_____
_____

---

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

32. Will you be working under hot conditions (temperature exceeding 77° F)? ❑ Yes ❑ No

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

34. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator? ❑ Yes ❑ No
If so, list clothing:_____

35. Have you ever worked with any of the materials or under any of the conditions listed below? ❑ Yes ❑ No

_____asbestos _____silica (sandblasting) _____tungsten/cobalt (grinding or welding)
_____beryllium _____aluminum _____coal (mining dust)
_____iron _____tin _____dusty environments
_____others, list: _____

If yes, describe these exposures:

_____
_____
_____
_____
_____

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

If so, name the medications if you know them:_____
_____
_____

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

Name of Substance	Estimated Maximum Exposure Level Per Shift	Duration of Exposure Per Shift

The name of any other toxic substances that you'll be exposed to while using your respirator: _____
_____
_____

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

_____
_____
_____

_____ _____/_____/_____ _____ _____/_____/_____
Patient Signature *Date* *Medical Examiner* *Date*