



New Jersey Law
REQUIRES
 Physicians,
 Advanced Practice Nurses,
 and Physician Assistants
 to report individuals
 diagnosed with
 work-related asthma.

Ask patients you are treating for **asthma** the following two questions:

1. Do your asthma symptoms usually start or get worse when you are at work and get better when you are away from work?
2. Are there any materials or activities at your job that you try to avoid because they make your asthma symptoms worse?

If he or she answered "Yes" to either of these questions, your patient may have **work-related asthma**.

Guidelines* to report cases of work-related asthma (new-onset or work-aggravated) to the NJDHSS:

POSSIBLE
 Symptoms of asthma and patient-reported work-related temporal pattern of symptoms of asthma

PROBABLE
 Diagnosis of asthma and patient-reported work-related temporal pattern of symptoms of asthma

CONFIRMED
 Diagnosis of asthma and objective evidence of work-relatedness

* More detailed information can be found in NJDHSS "Guidelines - Work-Related Asthma Recognition, Diagnosis, and Reporting." The Guidelines can be downloaded at <http://nj.gov/health/eoh/survweb/wra/index.shtml>.

See back of poster for contact information and copy of reporting form.



**OCCUPATIONAL AND ENVIRONMENTAL
 DISEASE, INJURY, OR POISONING REPORT
 BY HEALTH CARE PROVIDER**

*INSTRUCTIONS: In accordance with N.J.A.C. 8:58-1.5, health care providers must report any patient who is ill or diagnosed with any disease, injury, or poisoning listed below within 30 days after the disease, injury, or poisoning has been diagnosed or treated. In addition, suspect cases or patients with other occupational diseases may be reported. All information **MUST** be completed. Mail **complete** report to above address or fax to (609) 292-5677. Additional information, report forms, or business reply envelopes may be obtained from the above address, or by calling (609) 826-4984. This form is also available online in Microsoft Word and in PDF format at <http://nj.gov/health/surv>.*

Date _____

PATIENT INFORMATION			
Name of Patient (Print) _____ (First) (MI) (Last)			Date of Birth
Street Address			Age (if DOB Unavailable)
City	State	Zip Code	Home Telephone Number ()
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> White <input type="checkbox"/> Am. Ind./ Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other	Hispanic Origin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
DIAGNOSTIC INFORMATION			
Date of Onset of Disease, Injury, or Poisoning ____ / ____ / ____		<input type="checkbox"/> Lead Toxicity, Adult (Blood \geq 25 μ g/dl; Urine \geq 80 μ g/L) Blood = _____ μ g/dL Urine = _____ μ g/L	
Diagnosis: <input type="checkbox"/> Work-Related Asthma <input type="checkbox"/> Possible <input type="checkbox"/> Probable <input type="checkbox"/> Confirmed <input type="checkbox"/> Extrinsic Allergic Alveolitis <input type="checkbox"/> Silicosis <input type="checkbox"/> Asbestosis <input type="checkbox"/> Pneumoconiosis, Other and Unspecified <input type="checkbox"/> Occupational Dermatitis <input type="checkbox"/> Other Occupational Disease - Specify: _____		<input type="checkbox"/> Arsenic Toxicity, Adult (Blood \geq .07 μ g/mL; Urine \geq 100 μ g/L) Blood = _____ μ g /mL Urine = _____ μ g /L <input type="checkbox"/> Mercury Toxicity, Adult (Blood \geq 2.8 μ g/dL; Urine \geq 20 μ g/L) Blood = _____ μ g/dL Urine = _____ μ g/L <input type="checkbox"/> Cadmium Toxicity, Adult (Blood \geq 5 μ g/L whole blood; Urine \geq 3 μ g/gram creatinine) Blood = _____ μ g/L whole blood Urine = _____ μ g/gram creatinine	
Name and Address of Laboratory Which Performed the Testing, If Applicable			
Laboratory Name _____			
Street Address _____			
City _____		State _____	Zip _____
PLACE OF EXPOSURE / INJURY			
Company Where Exposure/Injury Occurred			
Name _____			
Street Address _____		Phone No. _____	
City _____		State _____	Zip _____
Job Title or Type of Work Performed by Patient		Patient-Reported Cause of Symptoms	
HEALTH CARE PROVIDER INFORMATION			
Name of Health Care Provider (Print)			Telephone Number ()
Address			
Facility Name _____			
Street Address _____			
City _____		State _____	Zip _____
Indicate Any Reasons Why the Patient Should <u>NOT</u> be Contacted		Comments by Health Care Provider, if Any	

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REPORTING INSTRUCTIONS: A Word or PDF version of the reporting form can be downloaded from our Web site at <http://nj.gov/health/eoh/survweb/wra/index.shtml>. Please send completed forms via fax at (609) 292-5677 or mail to:

**New Jersey Department of Health and Senior Services
 Environmental and Occupational Health Surveillance Program
 135 E State St, 4th floor
 PO Box 369
 Trenton NJ 08625-0369**

Questions? Contact the Work-Related Asthma Surveillance Coordinator at (609) 826-4984 or send an e-mail message to surveillance@doh.state.nj.us.