



HealthONE Occupational Medicine/Rehabilitation at North Suburban

9195 Grant Street, Suite 100
Thornton, CO 80229

FAX COVER SHEET

Date: ___/___/___

Time: _____AM / PM

To:

Corporate Management Group

Fax: 303-736-7767

Fax: _____

From: _____

Phone: 303-292-0034

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HEARING TEST FORM

Employee Identification

Last Name Wardell	First Name Christa	Middle Name Maree	Employee ID#	
Dept/Code		Job/Code	Work Shift	Shift Length

OCC HEALTH

DATE: 02/01/16
TIME: 14:30:12

PATIENT: 9157

CURRENT AUDIOGRAM

FREQ.	L/DB	R/DB
1000 HZ	10	05
500 HZ	05	05
V1000 HZ	10	05
2000 HZ	10	10
3000 HZ	15	10
4000 HZ	25	00
6000 HZ	15	15
8000 HZ	20	15
AVG 2,3,4	016.7	006.7

TEST ID: 2103411020615380

ELAPSED TIME = 05:47

TEST TYPE = BASELINE
TEST MODE = PULSED
M = MANUALLY TESTED FREQ

TRIEMETRICS RAS00+

SERIAL NUMBER...12115380
SOFTWARE REV. 2.19H-0102
CALIBRATION: 01/06/16
CAL. ANSI S3.6 1989

PATIENT: 9157

X C.W.

EXAMINER:

X ER

QUESTION ANSWERS

- LAST NAME:
- FIRST NAME:
- DOB:
- SEX:
- JOB TYPE:
- LOCATION:
- PROTECTION:
- EXPOSURE:

Audiometric Information

Test Date: **2/1/16**
Test Time: **1:15 am/pm**

Test Type: Baseline Annual/Periodic Retest Rehire Exit

Audiometer Make/Model:

RA500

Last Annual Calibration Date:

OSHA sound room requirements met? Yes No

Technician:

[Signature]

Technician:

Testing Company:

NCA

Employee Noise Exposure

High noise exposure within 14 hours: Yes No

Last noise exposure: _____ hours ago

Hearing protection used before test: Yes No

TWA:

Sound Level:

Hearing Protection Devices

Type Used Specify Model/Size

- Foam plug
- Pre-molded plug
- Custom plug
- Earmuff
- Plug & Muff
- Electronic
- Other

Otososcopic Screening

Left

-
-
-
-
-
-

- Was Not Done
- Normal
- Abnormal
- Partial blockage
- Total blockage
- Other

Right

-
-
-
-
-

Hearing Protection Fit Check: Proper Poor Re-instructed Replaced

Test Comments:

Employee Training:

The following topics have been explained to me:

1. The effects of noise on hearing
2. The purpose of the hearing test & explanation of procedures
3. Hearing protection use, care, fit and advantages/disadvantages

Employee Signature:

Christa Wardell

Date:

2/1/16

BC009.019 - Diisocyanates Medical Surveillance - Health Professionals Attachment 1
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BASF Corporation
Isocyanates Medical Surveillance - Health Professional

Respiratory Symptom Questionnaire

2/1/16
Date of Examination
Cherish Wandell
Employee's Name (Print)

Location
637-18-9157
Employee's Social Security Number

Please check the single best answer to each question

During the past four weeks:

- | | Yes | No |
|--------------------------------------------------------------------|--------------------------|-------------------------------------|
| 1.1. Has your chest felt tight or your breathing become difficult? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1.2. Has your chest sounded wheezing or whistling? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1.3. Have you had a persistent or regular cough? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 1.4. Have you developed a new skin rash? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If yes to any of the above, please answer the following questions:

- | | | |
|---------------------------------------------------------------------------|-----------------------------------|-------------------------------------|
| 2.1 If you run, or climb stairs fast do you | | |
| 2.1.1. | cough? | <input type="checkbox"/> |
| 2.1.2. | wheeze? | <input checked="" type="checkbox"/> |
| 2.1.3. | get tight in the chest? | <input checked="" type="checkbox"/> |
| 2.2 Is your sleep broken by | | |
| 2.2.1. | wheeze? | <input type="checkbox"/> |
| 2.2.2. | difficulty with breathing? | <input checked="" type="checkbox"/> |
| 2.3 Do you wake up in the morning (or from sleep, if a shift worker) with | | |
| 2.3.1. | wheeze? | <input type="checkbox"/> |
| 2.3.2. | difficulty with breathing? | <input checked="" type="checkbox"/> |
| 2.4 Do you wheeze | | |
| 2.4.1. | if you are in a smoky room? | <input type="checkbox"/> |
| 2.4.2. | if you are in a very dusty place? | <input checked="" type="checkbox"/> |

3.1 What happens to this on weekends? better same worse

3.2 What happens to this on holidays of 4 days or more? better same worse

3.3 Does this occur with exposure to a particular substance or process? Please describe.

No