



HOSPITAL SULTAN ABDUL AZIZ SHAH
UNIVERSITI PUTRA MALAYSIA
Kod Dokumen: HSAAS/UKA/BR47

NOTIFICATION OF OCCUPATIONAL LUNG DISEASE FORM

WEHU - L1
(JKKP 7)

Send to:
Pengarah Kesihatan Negeri
Jabatan Kesihatan Negeri _____

Part A - Detail of Notifier
(Regulation 7(2) Registered Medical Practitioner)

Name

Designation

Address of clinic/hospital

Contact no. _____

Part B - Affected person

Name

Date of birth / / DD MM YY
New IC/Passport no. _____
Nationality _____ Gender Male Female
Ethnic group _____ Occupation _____
Name and address of organization

District _____ State _____
Location of incident _____

Part C - Occupational Lung Disease

Date of diagnosis / / DD MM YY

Diagnosis/Provisional diagnosis _____

Part D

- a) What kind of work did the patient do which may be associated with the disease?
(Describe the work activities)
- b) What was the hazard or agent been exposed to the patient?
- c) How long had the patient been exposed to the hazard or agent?
- d) How long had the patient been experiencing the symptoms?

Signature of Notifier _____

Date _____

Name and address of attending doctor (Official Stamp)

1. Duration of symptoms (by years, months or days)

2. Type of occupational lung disease

- | | | | |
|--------------------------|---|--------------------------|--------------------------------------|
| <input type="checkbox"/> | Occupational asthma | <input type="checkbox"/> | Lung cancer |
| <input type="checkbox"/> | Inhalation incident | <input type="checkbox"/> | Mesothelioma |
| <input type="checkbox"/> | Hypersensitivity pneumonitis | <input type="checkbox"/> | Non - malignant pleural disease |
| <input type="checkbox"/> | Bronchitis/Emphysema | <input type="checkbox"/> | Byssinosis |
| <input type="checkbox"/> | Infectious diseases (e.g. TB) | <input type="checkbox"/> | Building related respiratory illness |
| <input type="checkbox"/> | Pneumoconiosis (incl. asbestosis, silicosis) | <input type="checkbox"/> | Fibrotic lung disease |
| <input type="checkbox"/> | Other occupational lung disease (please specify): _____ | | |

Suspected causal agent: _____

3. Source of case

- | | |
|--------------------------|---|
| <input type="checkbox"/> | Chest clinic |
| <input type="checkbox"/> | Occupational Health Clinic |
| <input type="checkbox"/> | Health Clinic (<i>Klinik Kesihatan</i>) |
| <input type="checkbox"/> | Other Specialist Clinic (please specify): _____ |
| <input type="checkbox"/> | Others (please specify): _____ |

4. Is patient a smoker?

- Current Ex-smoker Never smoked.

5. Is patient atopic?

- Yes No Unsure

6. Relevant job(s)

Type of work/industry	Job title	Duration of employment (by years, months or days)

7. Outcome on DD - MM - YY

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Still expose to the agent at the workplace but using personal protective equipment |
| <input type="checkbox"/> | Still expose to the agent at the workplace but not using personal protective equipment |
| <input type="checkbox"/> | Same place of work but no longer expose to agent. |
| <input type="checkbox"/> | Changed job/alternative employment |
| <input type="checkbox"/> | Away from work due to illness. |
| <input type="checkbox"/> | Early retirement |
| <input type="checkbox"/> | Unemployed |

8. Existing control

- Engineering Control
- Standard Operating Procedure (SOP)
- Training/Education/Work Schedule/Rotation
- Personal Protective Equipment (PPE)
- Other (please specify) _____