Physician's Report of Occupational Disease
Connecticut Departments of Labor and Public Health

This information is reportable by law within forty-eight (48) hours under CGS Sec.31-40a and confidential under CGS I-19(b)(2) and 19a-25

please type or write clearly

Date of Report:_____/_____/_____

I. Patient (Employee) Information

Name:_____SSN:_____/_____/_____
Last First MI

Address: _____
Street City State Zip Code

Home Phone #: ( ) _____-_____ Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Hispanic: ☐ Yes ☐ No ☐ Unknown Race: ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Other ☐ Unknown

Occupation (at time of exposure)_____(present)_____

II. Occupational Illness/Injury Information (ICD-9)

Repetitive Trauma Disorders
- ☐ Carpal Tunnel Syndrome (354.0)
- ☐ DeQuervains Syndrome (727.04)
- ☐ Epicondylitis (Tennis Elbow) (726.32)
- ☐ Hand-Arm Vibration Syndrome (443.0)
- ☐ Raynaud's Syndrome (443.0)
- ☐ Thoracic Outlet Syndrome (353.0)
- ☐ Trigger Finger (727.03)
- ☐ Vibration White Finger (443.0)
- ☐ Bursitis (site) _____ (727.3)
- ☐ Ganglion/ Cystic Tumor (site)_____ (727.4)
- ☐ Synovitis (site)_____ (727.0)
- ☐ Tendonitis (site)_____ (726.90)
- ☐ Tenosynovitis (site)_____ (727.0)
- ☐ OTHER (specify)_____ ( )

Respiratory Diseases/Disorders
- ☐ Allergic Rhinitis (477)
- ☐ Asbestosis (501)
- ☐ Asthma (493)
- ☐ Bronchitis (491)
- ☐ Pleural Plaques (511.0)
- ☐ Reactive Airway Dysfunction Syndrome (506)
- ☐ Rhinitis (472.0)
- ☐ Silicosis (502)
- ☐ Sinusitis (473)
- ☐ OTHER (specify)_____( )

Infectious Processes
- ☐ Hepatitis B (070.3)
- ☐ Tuberculin conversion (010)
- ☐ OTHER (specify)_____( )

Poisonings and toxic effects
- ☐ Carbon Monoxide (986)
- ☐ Lead (984) _____µg/dL (Attach copy of lab report)
- ☐ Solvents (982)
- ☐ Cancer (type)_____( )
- ☐ OTHER (specify)_____( )

Noise Disorders
- ☐ Hearing Loss (389)
- ☐ Tinnitis (388.3)
- ☐ OTHER (specify)_____( )

Skin Diseases/Disorders
- ☐ Contact Dermatitis (692)
- ☐ OTHER (specify)_____( )

☐ **Injury** (specify type and site on diagnosis line below)

Diagnosis (if not listed above):_____ICD-9(s) _____

Symptoms/Physical Findings:_____Date of First Symptom:____/____/____

Suspected causal factor(s) (i.e., object, substance or event):_____

Exposure: ☐ Acute ☐ Chronic Is patient exposure continuing? ☐ Yes ☐ No ☐ Unknown Are others likely to be affected? ☐ Yes ☐ No ☐ Unknown

Certainty of work relatedness: ☐ High ☐ Moderate ☐ Low Length of employment in occupation of concern: _____yrs_____months

Comments:_____

III. Employer Information (where exposure occurred)

Company Name:_____

Mailing Address:_____
Street City State Zip Code

Phone #: ( ) _____-_____ Work site location (if different than above)_____

IV. Health Care Provider Information

Name:_____
Last First MI (MD, RN, PA, Other)

Institution/Clinic name:_____

Mailing Address:_____
Street City State Zip Code

Phone #: ( ) _____-_____ Signature:_____

For more information call: (860) 566-4550 Labor Department or (860) 509-7740 Department of Public Health

Return to: State of Connecticut Labor Department, Division of Occupational Safety & Health, 38 Wolcott Hill Rd., Wethersfield, CT 06109

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