

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)

<p><u>Repetitive Trauma Disorders</u></p> <input type="checkbox"/> Carpal Tunnel Syndrome (354.0) <input type="checkbox"/> DeQuervains Syndrome (727.04) <input type="checkbox"/> Epicondylitis (Tennis Elbow) (726.32) <input type="checkbox"/> Hand-Arm Vibration Syndrome (443.0) <input type="checkbox"/> Raynaud's Syndrome (443.0) <input type="checkbox"/> Thoracic Outlet Syndrome (353.0) <input type="checkbox"/> Trigger Finger (727.03) <input type="checkbox"/> Vibration White Finger (443.0) <input type="checkbox"/> Bursitis (site) _____ (727.3) <input type="checkbox"/> Ganglion/ Cystic Tumor (site) _____ (727.4) <input type="checkbox"/> Synovitis (site) _____ (727.0) <input type="checkbox"/> Tendonitis (site) _____ (726.90) <input type="checkbox"/> Tenosynovitis (site) _____ (727.0) <input type="checkbox"/> OTHER (specify) _____ ()	<p><u>Respiratory Diseases/Disorders</u></p> <input type="checkbox"/> Allergic Rhinitis (477) <input type="checkbox"/> Asbestosis (501) <input type="checkbox"/> Asthma (493) <input type="checkbox"/> Bronchitis (491) <input type="checkbox"/> Pleural Plaques (511.0) <input type="checkbox"/> Reactive Airway Dysfunction Syndrome (506) <input type="checkbox"/> Rhinitis (472.0) <input type="checkbox"/> Silicosis (502) <input type="checkbox"/> Sinusitis (473) <input type="checkbox"/> OTHER (specify) _____ () <p><u>Infectious Processes</u></p> <input type="checkbox"/> Hepatitis B (070.3) <input type="checkbox"/> Tuberculin conversion (010) <input type="checkbox"/> OTHER (specify) _____ ()	<p><u>Poisonings and toxic effects</u></p> <input type="checkbox"/> Carbon Monoxide (986) <input type="checkbox"/> Lead (984) _____ μg/dL (Attach copy of lab report) <input type="checkbox"/> Solvents (982) <input type="checkbox"/> Cancer (type) _____ () <input type="checkbox"/> OTHER (specify) _____ () <p><u>Noise Disorders</u></p> <input type="checkbox"/> Hearing Loss (389) <input type="checkbox"/> Tinnitus (388.3) <input type="checkbox"/> OTHER (specify) _____ () <p><u>Skin Diseases/Disorders</u></p> <input type="checkbox"/> Contact Dermatitis (692) <input type="checkbox"/> OTHER (specify) _____ () <p><input type="checkbox"/> Injury (specify type and site on diagnosis line below)</p>
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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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