Report of Arterial Blood Gas Study

U.S. DEPARTMENT OF LABOR
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

OMB No. 1215-0090
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This report is authorized by law (30 USC 901 et. seq.) and required to obtain a benefit. The results of this interpretation will aid in determining the miner's eligibility for black lung benefits. Disclosure of a Social Security number is voluntary. The failure to disclose such number will not result in the denial of any right, benefit, or privilege to which the claimant may be entitled. This method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974, and OMB Circular No. 108.

Instructions: Summarized below are the procedures to be followed in administering this test. The arterial blood gas study shall initially be administered at rest and in a sitting position. If the results of the test at rest are not within the values indicated on the applicable table shown on the reverse side of this form, an exercise blood-gas study shall be offered to the miner unless medically contraindicated. *If an exercise blood gas test is administered, blood shall be drawn during exercise. Complete instructions for administration of this test and table of values may be found in 20 CFR Part 718, Subpart B, 718.105, and appendix C.

1. Name of Miner (First, middle, last)	2. SSN or DOL Claim No.	3. Date of Test (mm/dd/yyyy)

4. Miner's:
_____ Age
_____ Height
_____ Weight

5. Altitude: (Check one)
☐ ☐ 0 to 2999 feet above sea level
☐☐☐☐☐☐☐☐ 3000 to 5999 feet above sea level
☐☐☐☐☐☐☐☐ ☐6000 feet or more above sea level

6. Barometric Pressure
_____

Equipment Temperature
_____ Cº

7.
Site of Puncture: _____ Indwelling line: _____ Single stick: _____

8a.

	Time Sample Drawn	Iced Yes	Iced No	Time Sample Analyzed
Rest:	_____	_____	_____	_____
Exercise:*	_____	_____	_____	_____

b. Pulse rate at time sample drawn:
Rest: _____ Exercise: _____

c. Was equipment calibrated before and after each test?
☐☐☐☐ Yes☐☐☐☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐ No

d. Type of exercise and duration: *

9. Test Results	Predicted Normal Range	Observed Values: Resting	Observed Values: Exercise if Administered *
pCO_2 (mmHg)			
pO_2 (mmHg)			
pH			

*** Is the exercise portion of this study medically contraindicated?** ☐ Yes ☐ No
If YES, for what reason?

10. Additional Comments:

11a. Facility where test performed:

11b. Provider Number:

12. Print or type name of technician performing the study:

13. Print or type the name of the physician:

14. Physician's Signature: I certify that the information furnished is correct and am aware that my signature attests to the accuracy of the results reported. I am also aware than any person who willfully makes any false or misleading statement or representation in support of an application for benefits shall be guilty under 30 USC 941 of a misdemeanor and subject to a fine of up to $1000, or imprisonment for up to one year, or both.

Signature: Date:

Blood Gas Tables

The following tables set forth the values to be applied in determining whether total disability may be established in accordance with the criteria contained in 20 CFR 718.

(1) For arterial blood gas studies performed at test sites up to 2,999 feet above sea level:

Arterial pCO_2 (mmHg)	Arterial pO_2 equal to or less than (mmHg)
25 or below	75
26	74
27	73
28	72
29	71
30	70
31	69
32	68
33	67
34	66
35	65
36	64
37	63
38	62
39	61
40-49	60
Above 49	(1)

[1] Any Value

(2) For arterial blood gas studies performed at test sites 3,000 to 5,999 feet above sea level:

Arterial pCO_2 (mmHg)	Arterial pO_2 equal to or less than (mmHg)
25 or below	70
26	69
27	68
28	67
29	66
30	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40-49	55
Above 49	(2)

[2] Any Value

(3) For arterial blood gas studies performed at test sites 6,000 feet or more above sea level:

Arterial pCO_2 (mmHg)	Arterial pO_2 equal to or less than (mmHg)
25	65
26	64
27	63
28	62
29	61
30	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40-49	50
Above 49	(3)

[3] Any Value

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this information collection including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding these estimates or any other aspect of this survey, including suggestions for reducing this burden, send them to the Division of Coal Mine Workers' Compensation, U. S. Department of Labor, Room N-3464, 200 Constitution Avenue, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Note: Persons are not required to complete this collection of information unless it displays a currently valid OMB control number.