

Attachment 17 -
Spirometry Results Notification Form - Form No. CDC/NIOSH (M) 2.15

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|---|--|--|--------------------------------------|
| Spirometry Results Notification Form DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH | | NIOSH Coal Workers' Health Surveillance Program 1095 Willowdale Road, M/S LB208 Morgantown, WV 26505 Fax: 304-285-6058 | |
| SPIROMETRY FACILITY NAME | | FACILITY # | SPIROMETER UNIT # |
| MINER'S NAME (LAST, FIRST, MIDDLE INITIAL) | | MINER'S SOCIAL SECURITY NUMBER Full SSN is optional; last 4 digits are required | |
| MINER'S EMAIL ADDRESS | | DATE OF BIRTH _____ | SEX M F |
| RACE (check all that apply) American Indian or Alaska Native Asian Black or African American White Other | Ethnicity Hispanic or Latino Non-Hispanic or Latino | MINER'S HEIGHT (stocking feet) _____ cm or _____ inches | |
| | | MINER'S WEIGHT (stocking feet) _____ kg or _____ pounds | |
| | | BLOOD PRESSURE (resting) _____ / _____ | HEART RATE (resting) _____ |
| SPIROMETRY TECHNICIAN NUMBER | | SPIROMETRY TEST DATE | |
| SPIROMETER CALIBRATION CHECK DATE | | TEST ROOM CONDITIONS Temp ____ C ____ F Barometric Press ____ mmHg Relative Humidity ____ % | |
| TESTING POSITION Standing Seated | | <input type="checkbox"/> Electronic copies of the volume-time and flow-volume curves for the trials below are included with this form. | |

Spirometry Pre-Test Checklist

| Yes | No | For items 1 – 6, review "Yes" responses with supervising clinician before testing. |
|-----|----|---|
| | | 1. Systolic BP \geq 160; Diastolic BP \geq 100; or Pulse rate is >110 beats per minutes. If yes, review with supervising clinician before testing. |
| | | 2. Have you had any surgeries on your chest, abdomen, head, or eye (including Lasik) or had a heart attack or stroke in the last 6 weeks? If yes, consult supervising clinician before testing and consider reschedule after 6-8 weeks. |
| | | 3. Have you had a cold, flu, or respiratory infection in your chest within the last 3 weeks? If yes and symptoms still persist, consider reschedule in 6 weeks. |
| | | 4. Have you ever been told by a doctor that you have an aneurysm or a weakness in a major blood vessel? If yes, consult supervising clinician before testing. |

| Yes | No | |
|-----|----|---|
| | | 5. Have you ever had a collapsed lung (pneumothorax)? If yes, consult supervising clinician before testing. |
| | | 6. Have you coughed up any blood of unknown origin within the past 6 weeks? If yes, review with supervising clinician before testing. |
| | | 7. Have you eaten a heavy meal within the last hour? If yes, try to wait 1 hour before testing. |
| | | 8. Have you smoked within the last hour? If yes, try to wait 1 hour before testing. |

The certified spirometry clinic must record the spirometry results below if an electronic spirometry record is not submitted to NIOSH. The printed spirometry report must also be submitted with the results below or an electronic record.

| SPIROMETRY TEST RESULTS * | | | |
|--|--|---------|-------------|
| Trial # | | | |
| FVC (L) | | | |
| FEV1 (L) | | | |
| FEV6 (L) | | | |
| Peak Expiratory Flow (L/s) | | | |
| Extrapolated Volume (L) (Vext or BEV) | | | |
| Forced Expiratory Time (s) | | | |
| Technician's Evaluation of Miner's Effort | | Maximal | Sub-maximal |
| Uncertain | | | |

*Report results from 3 trials, which include the highest and second highest FVC and FEV1 values and the highest Peak Expiratory Flow value, from among all acceptable curves.

Please indicate when data was transmitted to NIOSH (MM/DD/YYYY):

| FAX Date | Mail Date | Electronic Date | Component Transmitted |
|----------|-----------|-----------------|--|
| | | | Respiratory Assessment Form |
| | | | Spirometry Results Notification Form |
| | | | Printed Spirometry Report (Including Calibration Report) |
| | | | Electronic Spirometry Results |

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0020).