

NOTIFICATION OF OCCUPATIONAL LUNG DISEASE

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

- Chest clinic
- Occupational Health Clinic
- Health Clinic (*Klinik Kesihatan*)
- Other Specialist Clinic (please specify): \_\_\_\_\_
- 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

- Still expose to the agent at the workplace but using personal protective equipment
- Still expose to the agent at the workplace but not using personal protective equipment
- Same place of work but no longer expose to agent
- Changed job/alternative employment
- Away from work due to illness
- Early retirement
- Unemployed

8. Existing control

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