



# New Mexico Occupational Health Registry Confidential Case Report

Please fax this form to NMOHR: Fax (505) 841-5895 or mail to the address below.

Name of person completing form:

Date completed:

## Demographic information

Name of ill or injured person (last name, first name, middle name)				DOB (mm/dd/yyyy)		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk.	
Address at time of visit (Street)				Race/ethnicity <input type="checkbox"/> White <input type="checkbox"/> Am. Indian or Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
City	County	State	Zip				
Phone	May we contact? Y <input type="checkbox"/> N <input type="checkbox"/>	Social Security Number		Hispanic ethnicity Y <input type="checkbox"/> N <input type="checkbox"/>		NM Tribal Code	
Age	Job status	Insured? Y <input type="checkbox"/> N <input type="checkbox"/>		Payer			

## Patient's visit and condition

Referred by	Date of visit	Date of diagnosis
Patient's complaint		
Diagnosis / ICD9	Exposure(s) related to diagnosis	
Comment		

## Conditions – as per New Mexico Administrative Code 7.4.3.13

<input type="checkbox"/> Asbestosis	<input type="checkbox"/> Mesothelioma
<input type="checkbox"/> Chronic beryllium lung disease	<input type="checkbox"/> Noise induced hearing loss
<input type="checkbox"/> Coal worker's pneumoconiosis	<input type="checkbox"/> Occupational asthma
<input type="checkbox"/> Heavy metal poisoning [As, Hg, Cd, Pb]	<input type="checkbox"/> Silicosis
<input type="checkbox"/> Hypersensitivity pneumonitis	<input type="checkbox"/> Other illness or injury
<input type="checkbox"/> Suspected pesticide poisoning	<input type="checkbox"/> Confirmed pesticide poisoning

## Occupation information (please complete for employment at time of suspected exposure)

Job title			Industry type		
Name of company			Company address (Street)		
City	State	Zip	Phone	Exposure/incident date or start date	Exposure end date
Other employers/exposures (include dates)					

## Reporting healthcare provider/healthcare facility/laboratory information

Name of physician	Physician specialty	Physician's phone			
Address (Street)	City	State	Zip		
Name of facility/laboratory	Phone number	Contact person			
Address (Street)	City	State	Zip		