



New Mexico Occupational Health Registry Confidential Case Report

When completed, please fax this form to NMOHR at (505) 827-0013

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				
Home 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 7.4.3.11

<input type="checkbox"/> Asbestosis	<input type="checkbox"/> Occupational burn hospitalization
<input type="checkbox"/> Coal worker's pneumoconiosis	<input type="checkbox"/> Occupational injury death
<input type="checkbox"/> Hypersensitivity pneumonitis	<input type="checkbox"/> Occupational pesticide poisoning
<input type="checkbox"/> Mesothelioma	<input type="checkbox"/> Occupational traumatic amputation
<input type="checkbox"/> Noise induced hearing loss	<input type="checkbox"/> Silicosis
<input type="checkbox"/> Occupational asthma	<input type="checkbox"/> Other illness or injury related to occupational exposure

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