Telephone Introduction for Patient Interviews

SILICOSIS NEXT-OF-KIN

1. Hello, my name is _________. I’m calling for Mr./Ms./Mrs. ________________. Is he/she in?

   (NO) I’m calling on behalf of the State of Michigan. When is a good time to reach him/her? Please tell him/her I called. Here is my phone number (toll free). He/she may call me at 1-800-446-7805.

   (YES) I’m calling on behalf of the State of Michigan. We are doing a special investigation into work-related breathing problems. Recently we sent you a letter asking for your help with this investigation.

2. Do you remember receiving the letter?

   (YES) Good. I’d like to take a moment to describe what you can do to help.

       (go to part 3)

   (NO) Let me see...I see that we mailed the letter to you on (date) to (address). Is that your correct address? If not, I will send you another copy of the letter. While I have you on the phone, let me explain briefly what the letter is about.

       (go to part 3)

3. Your participation in this investigation is completely voluntary. If you decide to participate, I will go through a questionnaire by phone. This takes approximately 30 minutes, and would complete your participation in the investigation. You indicate your voluntary participation by answering the questions. You can end your participation or refuse to answer individual questions at any time. All information you give us will be kept confidential. We do not share information from this investigation with any employers or insurance companies. The State of Michigan will use this information to understand more about work-related lung diseases and what can be done to prevent others from becoming sick.

4. Will you help us by participating in this questionnaire?

   (YES) Great, I will begin the questions now. (If as you start they indicate this isn’t a good time, arrange a time to call back.

   (NO) I see. May I ask what your concerns are?
SILICOSIS QUESTIONNAIRE
NEXT-OF-KIN

BACKGROUND INFORMATION

1. I want to confirm the spelling of the deceased’s name:

____________________________   ____________________   ____________________
First                  Middle         Last

I’d like to confirm your name: ______________________________

Relationship to deceased: ______________________________

Date individual died:   ___ ___- ___ ___- ___ ___ ___ ___ MM-DD-CCYY

State in which individual died: ___ ___

2. I want to confirm your address:

__________________________________________________
__________________________________________________

City   County  State Zip

3. I want to confirm your home phone number:

( ) ____________ - ______________

4. What was his/her social security number? (when possible, obtain from medical record in chart)

___ ___ - ___ ___ - ___ ___ ___ ___ ___

DEMOGRAPHIC INFORMATION

5. Gender of deceased? (do not ask if obvious)

Male   1   Female   2

6. What was his/her date of birth? (MM/DD/CCYY)

a. Was he/she of Hispanic origin?

7a. No   1   Yes   2   DK   9   ___ ___

7. How would he/she have been classified—the choices are:

*If OTHER, please specify:

____________________________

White 1

African American 2

Asian/Pacific Islander 3

Alaskan/American Indian 4

Other* 5

Unknown 9
**LIFETIME OCCUPATIONAL HISTORY**

**INSTRUCTIONS**

8. Please complete the following table below, listing all jobs at which you have worked for three months or more after completing school. Include time in the Armed Services, and any periods of time that you were laid off or not working. Start with your first full time job after leaving school and come up to your most recent job. If you had more than one job at the same company, use a new space for that job. Include any part time job where you were exposed to chemicals or dusts.

<table>
<thead>
<tr>
<th>WORKPLACE</th>
<th>TYPE OF INDUSTRY</th>
<th>DATES WORKED</th>
<th>JOB TITLE</th>
<th>DUTIES</th>
<th>EXPOSURES</th>
<th>PROTECTIVE EQUIPMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Name, Address, City and State</td>
<td>What do they do or manufacture? Is company still in business?</td>
<td>From: Mo/Yr</td>
<td>To: Mo/Yr</td>
<td>(Full Time or Part Time)</td>
<td>(Specify types of chemicals or dusts, if known)</td>
<td>(Gloves, masks, respirators, etc.)</td>
</tr>
<tr>
<td>1. FIRST JOB</td>
<td>Still in business? YES NO DK</td>
<td>FT? Yes No PT? Yes No</td>
<td>1 Yes Type: 2 No 3 DK</td>
<td>1 Yes Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. NEXT JOB</td>
<td>Still in business? YES NO DK</td>
<td>FT? Yes No PT? Yes No</td>
<td>1 Yes Type: 2 No 3 DK</td>
<td>1 Yes 2 No Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. NEXT JOB</td>
<td>Still in business? YES NO DK</td>
<td>FT? Yes No PT? Yes No</td>
<td>1 Yes Type: 2 No 3 DK</td>
<td>1 Yes 2 No Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. NEXT JOB</td>
<td>Still in business? YES NO DK</td>
<td>FT? Yes No PT? Yes No</td>
<td>1 Yes Type: 2 No 3 DK</td>
<td>1 Yes 2 No Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. NEXT JOB</td>
<td>Still in business? YES NO DK</td>
<td>FT? Yes No PT? Yes No</td>
<td>1 Yes Type: 2 No 3 DK</td>
<td>1 Yes 2 No Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. NEXT JOB</td>
<td>Still in business? YES NO DK</td>
<td>FT? Yes No PT? Yes No</td>
<td>1 Yes Type: 2 No 3 DK</td>
<td>1 Yes 2 No Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. NEXT JOB</td>
<td>Still in business? YES NO DK</td>
<td>FT? Yes No PT? Yes No</td>
<td>1 Yes Type: 2 No 3 DK</td>
<td>1 Yes 2 No Type:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. NEXT JOB</td>
<td>Still in business? YES NO DK</td>
<td>FT? Yes No PT? Yes No</td>
<td>1 Yes Type: 2 No 3 DK</td>
<td>1 Yes 2 No Type:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. Primary Employment:

Year Started: 8. _____ _____ CCYY started

Year Stopped: _____ _____ CCYY stopped

Silica Exposure? No 1 Yes 2 DK 3

Standard Industrial Classification: _____ _____ SIC (1987)

Census Occupation Code: _____ _____ COC (1990)

County: _____ County

Primary Industry Narrative: ______________________________

Primary Occupation Narrative: ____________________________

9. Secondary Employment:

Year Started: 9. _____ _____ CCYY started

Year Stopped: _____ _____ CCYY stopped

Silica Exposure? No 1 Yes 2 DK 3

Standard Industrial Classification: _____ _____ SIC (1987)

Census Occupation Code: _____ _____ COC (1990)

_____ _____ COC (2000)


_____ _____ _____ NAICS (2002)

10. Tertiary Employment:

Year Started: 10. _____ _____ CCYY started

Year Stopped: _____ _____ CCYY stopped

Standard Industrial Classification: _____ _____ SIC (1987)

Census Occupation Code: _____ _____ COC (1990)

_____ _____ COC (2000)


_____ _____ _____ NAICS (2002)
11. a. Had the deceased ever worked in a coal mine?  
   If YES, did he/she work below ground?  
   b. Had the deceased ever done sandblasting?  
   If YES, which job(s)?  
   c. Was the deceased ever exposed to asbestos?  
   If YES, which job(s)?  

   Please describe how he/she was exposed to asbestos:

11a. No 1 Yes 2 DK 3  
11b. No 1 Yes 2 DK 3  
11c. No 1 Yes 2 DK 3

TOBACCO SMOKING

12. Did the deceased ever smoke cigarettes? (NO means less than 5 packs of cigarettes or 12 oz. of tobacco in a lifetime.)  
   If NO, go to question 16  
13. How old was he/she when he/she FIRST started smoking cigarettes?  
14. If he/she STOPPED SMOKING COMPLETELY, how old was he/she when he/she stopped?  
15. On the average of the entire time he/she have smoked, how many cigarettes did he/she smoke per day? (20 cigarettes/pack)

12. No 1 Yes 2 DK 3  
13. ___ ___ age started smoking  
14. ___ ___ age stopped smoking  
15. ___ ___ average cigarettes/day

MEDICAL SURVEILLANCE

16. Had the deceased ever been told that he/she had tuberculosis?  
   If YES, in what year was he/she told he/she had tuberculosis?  
17. Had the deceased ever had a skin test for tuberculosis?  
   a. If YES, what was the last year it was done?  
   b. If YES, what was the result?  
   c. If POSITIVE, what was the last year it was negative?  
17a. ___ ___ ___ ___ CCYY  
17b. Negative 1 Positive 2  
17c. ___ ___ ___ ___ CCYY

34a. Had the deceased ever been diagnosed with kidney disease?  
   If YES, in what year?  
34a-1. ___ ___ ___ ___ CCYY

34b. Had the deceased ever been diagnosed with a connective tissue disease, such as lupus, scleroderma or rheumatoid arthritis (only include arthritis if rheumatoid arthritis. If not rheumatoid or DK if rheumatoid, then answer NO to 33b and go to 33c).  
   If YES, type:  
   If YES, in what year?  
34b-1. ___ ___ ___ ___ CCYY
34c. Did the deceased have arthritis?  
   If YES, did a health care provider confirm they had arthritis?  
   If YES, in what year?  
34c. No 1 Yes 2 DK 3  
34c-1. No 1 Yes 2 DK 3  
34c-2. ____ ____ ____ CCYY

WORKERS’ COMPENSATION  
Indicate below if compensated for BLACK LUNG.

18. Had the deceased ever filed a workers’ compensation claim for a lung condition?  
   18. No 1 Yes 2 DK 3

   Indicate who filed: ________________________________

19. If YES, what is the status of the claim?  
   19. Denied 1 Awarded 2 Pending 3 Unknown 9

   a. If the patient worked in a coal mine, had the deceased or his/her spouse filed for BLACK LUNG benefits?  
   19a. No 1 Yes 2 DK 3

MEDICAL CARE

20. Could you tell use the name and location of any physician and/or hospital where the deceased received care for his/her lung condition? Also, list dates and whether he/she had breathing tests and/or chest x-rays. We are interested in obtaining copies of these tests, please identify testing performed in the last five years.

   Health Care Provider: ________________________________  
   Chest X-Ray YES NO
   ________________  
   Breathing Test YES NO
   ________________  
   Dates: ________________

   Health Care Provider: ________________________________  
   Chest X-Ray YES NO
   ________________  
   Breathing Test YES NO
   ________________  
   Dates: ________________

   Health Care Provider: ________________________________  
   Chest X-Ray YES NO
   ________________  
   Breathing Test YES NO
   ________________  
   Dates: ________________

   Health Care Provider: ________________________________  
   Chest X-Ray YES NO
   ________________  
   Breathing Test YES NO
   ________________  
   Dates: ________________

Last Revised: 04/13/2011
21. Deceased:
   a. Cause of death:
   b. Death certificate SIC:
   c. Death certificate Census Occupation Code:
   d. Age at death:
   e. Date of death:

21a. ___ ___ ___ ___ cause of death
21b. ___ ___ ___ ___ SIC
21c. ___ ___ ___ COC
21d. ___ ___ ___ ___ age in years
21e. ___ - ___ - ___ - ___ - ___ - ___ MM-DD-CCYY

22. Filed for WC from DOL?
   If YES, claims status:

22. No 1 Yes 2 DK 3

   Denied 1     Awarded 2
   Pending 3    Unknown 9

23. Clinical Radiology Report available:

   Date of X-Ray
   Parenchyma
   PMF:

23. Inconsistent 1
   Consistent 2
   Inconclusive 3
   No Report Available 4

   ___ - ___ - ___ - ___ MM-CCYY

   ___ ___ parenchyma
   ___ PMF

24. Pulmonary Function Testing (most recent results):
   a. Percent Predicted FVC:
   b. Percent Predicted FEV₁:
   c. FEV₁ (liters):
   d. FVC (liters):
   e. Percent Predicted MMFR:
   f. MMFR (liters per second):
   g. Date of PFTs:

24a. ___ ___ ___
24b. ___ ___ ___
24c. ___ - ___ ___
24d. ___ - ___ ___
24e. ___ ___ ___
24f. ___ - ___ ___
24g. ___ - ___ - ___ ___ MM-CCYY

25. Physician considered TB diagnosis?

25. No 1 Yes 2 DK 3

26. Lung biopsy done?

26. No 1 Yes 2 DK 3

   Consistent w/ silicosis 1
   Consistent w/ other pneu 2
   Inconclusive for silicosis 3
   Inconsistent w/ pneum 4
27. Ascertainment year (year report received in office): ___ ___ ___ ___ CCYY
28. Reporting source for the initial case report:
   If OTHER, describe: 
   ________________________________
   ________________________________________________________________________
   Physician report 01
   Outpatient clinic report 02
   Other HC provider report 03
   Hospital Disch rec rev 12
   Death certificate 30
   Routine health screen 33
   Workers’ comp 40
   Self-report 50
   Co-worker report 51
   MSHA (Mine Safety) 60
   Referral other state 80
   Other* 88
29. Year recorded on initial reporting source records: ___ ___ ___ ___ CCYY
30. Reporting source:
   If physician, physician type: ___ ___ ___ ___
   If physician, physician’s last name:
   ________________________________
   ________________________________________________________________________
   No 1 Yes 2 DK 3
31. Is age an estimate? 31. No 1 Yes 2 DK 3
32. ILO report available?
   Inconsistent 1
   Consistent 2
   Inconclusive 3
   No x-ray available 4
33. Other imaging results?
   Yes, consistent w/ silicosis 1
   Yes, inconsistent w/ silicosis 2
   Yes, inconclusive for silicosis 3
   No other results available 4