Telephone Introduction for Patient Interviews

Cholinesterase Testing

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 do you expect him/her home? Please tell him/her I called. My toll-free telephone number is 1-800-446-7805.

   (YES) I’m calling on behalf of the State of Michigan. We receive reports of all blood cholinesterase levels, and we have received your blood cholinesterase report. We sent you a letter asking for your help in our special investigation into determining if pesticide exposure is affecting your cholinesterase level.

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. We are making follow up telephone calls to people who have had their blood cholinesterase level checked. We received a report of your blood cholinesterase level of ___ taken on _________(date).

   Your participation in this investigation is completely voluntary. If you decide to participate, I will go through a questionnaire by phone. This takes approximately 15 minutes, and would complete your participation in this 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 strictly confidential. We do not share this information with your employer. The State of Michigan will use this information to understand more about pesticide exposure in the State. If your exposure to pesticides occurred from work and you are still working at the location where you were exposed, you may benefit if the results of this investigation lead to changes in your workplace.

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

   (YES) If this is a good time to do the questionnaire, I will begin with the questions now. (If this is not a good time, arrange a day and time to call back.)

   (NO) I see. May I ask what your concerns are?
Please complete the following questionnaire to the best of your knowledge. If you have any questions or if you wish to complete the questionnaire over the telephone, please call Dr. Kenneth Rosenman or his staff at their toll-free telephone number: 1-800-446-7805.

1. What is your full name?
   
   ___________________________     ___________________________
   First     Middle
   Last

2. What is your address?
   
   __________________________________________________________
   __________________________________________________________
   City          State    Zip

3. What is your home telephone number?
   
   (        ) ____________ - ______________

4. What is your social security number?
   (If refusal to answer, try to obtain the last 4-digits)

4. ___ ___ - ___ ___ - ___ ___ ___ ___

5. What is your gender?

5. Male 1 Female 2

6. What is your date of birth?
   (Confirm DOB if available in chart.)

6. ___ ___ - ___ ___ - ___ ___ ___ ___

7. How would you be classified? The choices are:

7. White 1
   African American 2
   Asian/Pacific Islander 3
   Native American/Alaskan 4
   Other 5
   Unknown 9

8. Are you of Hispanic origin?

8. No 1 Yes 2 DK 3
9. Did you have any health symptoms on ________ (date) when your cholinesterase level was checked?
   ___ No
   ___ Yes
   If yes, please circle any symptoms below:

<table>
<thead>
<tr>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>General:</td>
</tr>
<tr>
<td>Dermal:</td>
</tr>
<tr>
<td>Gastrointestinal:</td>
</tr>
<tr>
<td>Neurological:</td>
</tr>
<tr>
<td>Respiratory:</td>
</tr>
<tr>
<td>Cardiovascular:</td>
</tr>
<tr>
<td>Ocular:</td>
</tr>
<tr>
<td>Renal:</td>
</tr>
</tbody>
</table>

If YES to any of the Health Symptoms listed above, ask questions 10-14.

10. When did your symptoms start (circle all that apply)? Immediately, that day, next day, other ________

11. Have the symptoms stopped completely?
   ___ Yes  If yes: When did the symptoms stop? _____________________________
   ___ No   If no: Which symptoms do you still have? _________________________

12. Did you get medical care following this exposure?
   ___ No   If NO: a. Why not: _____________________________________________
   ___ Yes  If YES: b. Where did you first go for your care?

   ___ Doctors office or clinic
   ___ Emergency room in a hospital
   ___ Urgent Care Facility
   ___ Advice from poison control center
   ___ Other (list): ________________________________________

If YES and we do not already have copies of medical records, ask c and d:

c. What was the name and address of the (clinic/hospital/doctor)?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

d. When did you first go there?  Mo____Dy____Yr____

   e. Did you see anyone for medical care after that?
      ___ No (skip to next question)
      ___ Yes
      If yes: Who? __________________________
      Where was this?

13. How many hours and/or days, if any, did you lose from work because of your symptoms?
   ________ Hours ________ Days ________ None
14. Did you file a claim with Workers’ Compensation to pay for medical care or lost work time?
   ___Yes. If yes, what is the status of your claim? ___Denied ___Awarded ___Pending
   ___No

15. Did any of your co-workers have symptoms from this exposure?
   ___Yes  If yes, how many? __________________
   ___No
   ___Unknown

16. Did any of your co-workers seek medical care?
   ___Yes
   ___No
   ___Unknown

   Comments: ______________________________________
               ______________________________________

Now I’m going to ask you some questions about your medical history that do not relate to the pesticide exposure.

17. Do you have (circle yes or no):

<table>
<thead>
<tr>
<th>Describe</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Skin condition Y/N</td>
<td></td>
</tr>
<tr>
<td>b. Heart condition such as angina or a past heart attack Y/N</td>
<td></td>
</tr>
<tr>
<td>c. High blood pressure Y/N</td>
<td></td>
</tr>
<tr>
<td>d. Diabetes Y/N</td>
<td></td>
</tr>
</tbody>
</table>
| e. Acquired Chemical Intolerance/
  Multiple Chemical Sensitivity Y/N                  |             |
| f. Asthma Y/N                                      |             |
| g. Allergies Y/N                                   |             |
| h. Pregnant at time or since Y/N
  (skip if male)                                      |             |
18. Was your cholinesterase blood test of _________ (date of test) part of a company medical screening?  

If YES:

a. Are you notified of your Blood Cholinesterase results?  
b. If Q16a YES, are you given the results in writing?  
c. Did a doctor or nurse, employed by your company, examine you because of your Cholinesterase results?

Please tell us the name of the company doctor, nurse or mobile service that drew your blood sample:


If NO or DK if testing was part of a company medical screening:

d. Did you go to your own doctor for the blood test?  

Please tell us the name and location of the doctor that drew your blood sample:


19. Is individual self-employed?  

20. Why did your doctor have your blood tested for cholinesterase?  

21. How were/are you exposed to pesticides?  

22. What is the name, city and state of the employer you were working at when your blood was tested for cholinesterase?  

City     State

23. What does this employer do or manufacture?  

24. What job did you have when the blood test was taken?
25. On this job, how many people also work(ed) as (occupation)?

26. Can you tell me more about what you do/did as (occupation), what pesticides you use, what you are making, the area you work in, and what you do on your job? 
*INTERVIEWER:* very important, try to get detail.

Materials: __________________________________________________________

_________________________________________________________________

Worksite description: _____________________________________________

_________________________________________________________________

Work process: ____________________________________________________

_________________________________________________________________

27. a. What month and year did you begin working for 
  (employer name where Pesticides exposure occurred, see Q28)?
  \[M\]  \[M\]  \[C\]  \[C\]  \[Y\]  \[Y\]

b. What month and year did you start as 
  (occupation where Pesticides exposure occurred, see Q28)?
  \[M\]  \[M\]  \[C\]  \[C\]  \[Y\]  \[Y\]

For Applicators only:

28. Are you a

  _____certified pesticide handler
  _____registered pesticide handler
  _____neither certified nor registered
  _____unknown

If not certified, did you have

  _____constant supervision
  _____intermittent supervision
  _____no supervision

29. If not certified or registered, please describe your training for 
pesticide application and handling.

_________________________________________________________________

30. What type of equipment did you/the applicator use?

  ___ aerial application  ___ sprayer, air blast
  ___ aerosol can   ___ sprayer, backpack
  ___ duster   ___ sprayer, boom
  ___ fogger   ___ sprayer, ultra low volume
  ___ hand held granular applicator   ___ squirt bottle
  ___ hand held line   ___ more than one type of equipment
  ___ hydraulic, high pressure   ___ other
  ___ hydraulic, low pressure   ___ not applicable
  ___ soil injector   ___ unknown

31. What was the target (e.g. weeds, insects)?

32. Do you know the name of the pesticides(s) you were working with or exposed to?

  ___ Yes: Specify
  ___ No  If no: Is there a place to find out the name?

  ___ Yes: Where

  ___ No  If no: Do you know the active ingredient(s)?
33. If you handled the pesticide directly, did you learn from the label how to use it?
   ___ Yes
   ___ No
   Comments: ____________________________________________________________

34. Do you know what PPE was required according to the pesticide label?
   ___ Yes If yes, did you wear required PPE? ___ Yes ___ No
   ___ No
   Comments (If PPE was required but not used, ask for an explanation): _______________
   __________________________________________________________________________

35. Were you wearing any personal protective equipment at the time? ___ Yes ___ No
   If yes:
   ___ respiratory protection
   ___ supplied air
   ___ respirator
     what color cartridge was in there? __________
     how old was it? __________
     had it been fit tested? __________
   ___ dust mask
   ___ clothing
     ___ long sleeved shirt
     ___ long pants
     ___ something covering head (hat/scarf)
     ___ something covering neck
     ___ other: _____________________________________________
   ___ boots, work or rubber /chemically resistant
   ___ gloves, natural or synthetic or other (circle one)
   ___ sun/prescription glasses, safety glasses, goggles or a face shield (circle one)
   ___ chemically resistant clothing (rubber apron, tyvek suit, rain gear)
   ___ Engineering (i.e., enclosed cab, exhaust hood, mixing area with berm)

For Farmworkers only:

36. Did the exposure take place because you entered a treated area?
   ___ Yes, before re-entry interval was over
   ___ Yes, after re-entry interval was over
   ___ Yes, unknown if re-entry interval was
     If yes, why, and for how long? ________________________________
   ___ No
   ___ Don’t Know

37. Was the treated area posted?
   ___ Yes
   ___ No
   ___ Not Applicable
   ___ Don’t Know

38. Were you told that season about the hazards of pesticides? Yes 1 No 2 DK 3
39. Were you told that season about how to get emergency care? Yes 1 No 2 DK 3
40. Is there a safety poster on display in a central location, with information on where to get medical care? Yes 1 No 2 DK 3
The Michigan Department of Energy, Labor and Economic Growth and the Michigan Department of Agriculture have the legal responsibility to inspect your workplace. Would you be concerned if they inspected your workplace even though your name would be kept completely confidential?

NO ___ YES ___ N/A ___

If YES, what exactly are your concerns?

__________________________________________________________________________

__________________________________________________________________________

What can we do to minimize your concerns?

__________________________________________________________________________

__________________________________________________________________________

What is the DEPARTMENT and BUILDING or ADDRESS where you work with pesticides including mixing?

__________________________________________________________________________

__________________________________________________________________________

Please describe how we would find the actual LOCATION where you were exposed to pesticides:

__________________________________________________________________________

__________________________________________________________________________