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?

CHOLINESTERASE QUESTIONNAIRE

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.

Office Use Only

ID # C ___ ___ ___ ___

RecNo. 1

Iview Date: __ __ - __ __ - __ __ __ __

Interviewer: __ __ __ (initials)

1. What is your full name?

_____ _____ _____
First Middle Last

1. ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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

HEALTH DATA

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

Symptoms	
General:	tired, fever, achy
Dermal:	redness, rash, pain, itching, swelling
Gastrointestinal:	stomach pain, nausea, vomiting, diarrhea, irregular bowels
Neurological:	headache, dizziness, muscle pain or weakness, sweating, fainting
Respiratory:	cough, trouble breathing, wheezing, sore throat
Cardiovascular:	chest pain, irregular heartbeat
Ocular:	tearing, itchy eyes, pain
Renal:	frequency in urination, etc.

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):

	Describe	Medications
a. Skin condition Y/N		
b. Heart condition such as angina or a past heart attack Y/N		
c. High blood pressure Y/N		
d. Diabetes Y/N		
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? No 1 Yes 2 DK 3

If YES:

a. Are you notified of your Blood Cholinesterase results? No 1 Yes 2 DK 3
b. If Q16a YES, are you given the results in writing? No 1 Yes 2 DK 3
c Did a doctor or nurse, employed by your company, examine you because of your Cholinesterase results? No 1 Yes 2 DK 3

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? No 1 Yes 2 DK 3

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

_____

_____

_____

19. Is individual self-employed? No 1 Yes 2 DK 3

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)? ___ ___ ___ ___
number of people

26. Can you tell me more about what you do/did as a (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
___ aerosol can
___ duster
___ fogger
___ hand held granular applicator
___ hand held line
___ hydraulic, high pressure
___ hydraulic, low pressure
___ soil injector
___ sprayer, air blast
___ sprayer, backpack
___ sprayer, boom
___ sprayer, ultra low volume
___ squirt bottle
___ more than one type of equipment
___ other
___ not applicable
___ 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

41. 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 work place 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:

_____

_____.