The Building Trades National Medical Screening Program

CONSENT TO PARTICIPATE IN A MEDICAL EXAMINATION (Stage 3)

As part of the Building Trades National Medical Screening Program, you recently completed a Work History Questionnaire. As a result of that questionnaire, a team of occupational health specialists determined that a medical examination is advisable for you. This examination is designed to provide you with a limited evaluation of your current health and to assess your risks for future disease as it relates to the work you performed on a DOE site. The examination is entirely ***voluntary.*** We hope that you will take advantage of all the examinations and tests suggested for you. However, you are free to refuse any part, or all, of what is offered and you are free to discontinue your participation in this program at any time by simply notifying the Program Office at the number provided below.

I. PURPOSE

The purpose of the Building Trades National Medical Screening Program is:

1) To provide an evaluation of your current health status as it relates to your work history on a DOE site.
2) To discover previously undiagnosed illnesses.
3) To discover risk factors for diseases which could develop in the future
4) To educate you on how to reduce risk factors.
5) To reassure workers who are found to be free of illness or risk factors.
6) To collect information in a systematic way to look for trends in groupings of information, or for other purposes that might prove beneficial to workers.

This Program is ***not*** the same as a general comprehensive health exam that you normally receive from your personal physician. It is limited to an evaluation of possible diseases that may have been caused by exposures to specific hazards while you worked on a DOE site. This Program is ***not*** designed to provide additional ***diagnostic*** testing for abnormalities discovered on screening tests and is ***not*** designed to provide ***treatment*** for any diseases or conditions identified during the study. You will be referred to your own physician or advised of the appropriate specialty consultation needed for any additional tests or treatment. The procedures you will be asked to follow, the type of information you will receive, the potential risks of participation, and the measures we have taken to preserve the confidentiality of your records are described below.

II. PROCEDURES

1. Consent to Participate in a Medical Examination (Stage 3) – The first step in the process is for you to clearly understand what the Program will and will not provide and to indicate that understanding by signing the consent form. You may list on the last page which, if any, examinations or tests you do not wish to receive. No examinations or tests can be performed without your consent.
2. Patient Questionnaire – You will be asked to fill out a health questionnaire that will include information such as your age, gender and other personal characteristics as well as your current and past occupations, your family medical history, and other information that is relevant to this program. If you have difficulty filling out the questionnaire, one of our staff will assist you. A staff member will review the questionnaire with you for completeness when you are finished.
3. Occupational History Interview – You will be asked to complete an occupational history questionnaire and may be interviewed, as well, by a trained professional who will collect additional information related to your work history.
4. History and Physical Examination by a Physician – You will meet with a physician and/or other professional staff working under a physician's supervision who will review your current and past medical history with you and perform the physical examination.
5. Laboratory Tests – Blood and urine samples will be obtained for a series of screening tests which will include blood counts, blood salts, liver and kidney function tests, blood sugar, cholesterol and a urinalysis. Depending on where you worked on a DOE site, and for how long, blood samples may be taken for other specific tests as well. You will be provided with a list of the tests recommended for you and specific procedures will be explained, including the amounts of and number of times blood and urine will be taken. Your blood will not be tested for drugs or HIV antibodies (AIDS).
6. Beryllium Blood Test - Unless you have tested abnormal for beryllium in the past, you will be offered a blood test for beryllium exposures called the Beryllium Lymphocyte Proliferation Test (Be-LPT). You will be provided additional information regarding the LPT test and what it means.
7. X-ray Examinations – You may be offered a chest x-ray if we determine that one is needed based on your work history. Women who may be pregnant or trying to conceive will be offered the chest x-ray at a later date.
8. **Pulmonary Function Test (spirometry)** – You will be offered a breathing test.
9. **Audiometry** – A hearing test will be offered if determined to be necessary.

III. INFORMATION YOU WILL RECEIVE

After your tests have been analyzed by professionals assigned to this Program, you will receive a letter summarizing the examinations and tests you had and copies of the results of those tests. Letters will be sent by first-class mail and are usually sent out no later than 8-weeks after the examination takes place. We will ask you to fill out a satisfaction questionnaire that will be included in the package

and return it so that we know you have received your results. ***If you have not received your results within eight (8) weeks of the examination, please call the Program office at 1-800-866-9663.***

You should show your results to your personal physician. We may contact you by phone or letter to follow-up on any abnormalities that may be found from the examinations or to discuss the recommendations provided in the results letter.

Note: Some State Workers' Compensation laws require that you file a claim within a very limited time after a doctor has told you that you may have an illness that is or may be related to your work. Some State laws also require you to inform your employer or former employers if you plan to file a Workers' Compensation claim.

A program for DOE workers was enacted in 2000 that compensates workers who qualify, or their survivors, for medical costs incurred for certain toxic illnesses that may have resulted from their work on a DOE site. We will provide more information on this compensation program with your results letter.

If the medical examination finds serious or potentially serious health problems that need follow-up the Program will assist you with referral to a qualified specialist, but we are not authorized to pay for any additional medical care other than what is provided in the examination.

IV. RISKS

The risks of participating in this examination are very small. The blood drawing may include pain or bruising where the blood is drawn or, less commonly, formation of a small blood clot or swelling of the vein and surrounding tissue, and bleeding from the puncture site. There are no known risks from hearing tests. Rarely, participants may become light-headed, faint, or experience breathing problems during the lung function tests. The chest X-ray includes exposure to X-rays, which is a form of radiation. This exposure has been minimized as much as possible and it is believed that the benefits of the examination exceed the risks from exposure to the X-rays. Also, as noted above, the Program can not pay for any additional tests.

The greatest "risk" from participation in the Program is the possibility of being referred for additional testing to clarify screening test abnormalities. While waiting for abnormalities to be clarified, you may experience anxiety and worry. Follow-up testing is a normal occurrence because many screening tests are imperfect so a second test may be required to confirm earlier results.

V. CONFIDENTIALITY AND USE OF PROGRAM DATA

All personal information gathered from you for this Program will be kept strictly private. It will be entered into a secure data base that is password protected and accessible only by assigned program personnel. No information with your personal identifiers will be released or used for any purpose other than this Program, unless authorized by you to your personal physician, or as you indicated when you first consented to participate in this Program. When the Program ends, a copy of your Program file will be sent to you and the Program will remove all your personal identifiers, such as name, address, and social security number from our file. Release of personal identifiers and de-identified date will be handled in the manner you chose when you consent to participate in this Program.

The blood and urine you provide during these examinations will be used for this purpose only and will be destroyed following analysis of the samples.

Data files without any information that can identify you may be used by our Program staff or other researchers to better understand the types of risks workers may be exposed to, or to determine how well this program is meeting its objectives. Information from such research will be used to protect workers like you better in the future.

VI. REFUSAL TO PARTICIPATE IN CERTAIN EXAMINATIONS OR TESTS

In order for us to provide a comprehensive evaluation of your health, it is important that you answer all of the questions and participate in the examination and tests that have been recommended for you. You are free, however, to refuse any part of the examination or the individual tests by listing them below.

Tests or examinations I <u>do not</u> want to participate in:

This Program is entirely voluntary and without cost to you. You will not be compensated for your participation. However, you may benefit in increased knowledge about your personal health. Your participation may also benefit future workers by helping to identify trends in groupings of information that may be important to their health and well-being.

If you have questions regarding your rights as a human subject in this Program, you may contact the Central Department of Energy Institutional Review Board at 865-574-4359.You are free to refuse any part of the program and may withdraw from the program or ask questions regarding your participation at any time by contacting the Program Office at 1-800-866-9663. Dr. Rick Rinehart, Principal Investigator, or any of the assigned project personnel can help you. You can also find useful information on our website www.btmed.org.

PARTICIPANT'S CONSENT

I have read the above information and all my questions thus far have been answered. By signing this consent form, I agree to participate in the Program and comply with the requirements of participation in Stage 3 as they have been described to me. I am free to ask questions, refuse any part of the Program, or discontinue my participation at any time by contacting the Program office and that I will receive a signed copy of this consent. I noted my preferences for the use of my identified and de-identified data in the consent form for Stage 1 of this program with the understanding that my decisions will be respected and will not influence my ability to participate in this Program.

Signature: _____Date_____

Name (Please print): _____

Phone: (_____)_____

Address: _____

City: _____ State: _____ Zip: _____

Legally Authorized Representative: _____

A WITNESS IS REQUIRED

(A spouse or friend may be used to witness your signature.)

Witness Signature: _____

Witness Name: _____

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