

FILE NAME: Talc (TALC)

DATE: 1989

DOC#: TALC043

DOCUMENT DESCRIPTION: Worker's Comp Claim

CHECK TYPE OF DOCTOR:

CHECK TYPE OF DOCTOR:

☒ PHYSICIAN ☐ PODIATRIST ☐ CHIROPRACTOR

PLEASE PRINT OR TYPE

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY AND TIME	ADDRESS WHERE INJURY OCCURRED (City, Town or Village)	INJURED PERSON'S SOC. SEC. NO.
		late 1970's	Balmar, NY	721-07-4499
JURED PERSON	William Douglas Bowman (First Name) (Middle Initial) (Last Name)	AGE 63	ADDRESS (Include Apt. No.) Gouverneur, NY 13642 Box 342	TELEPHONE NO. 287-0432
EMPLOYER	St. Joes Resource Co		Balmar, NY	
INSURANCE CARRIER	Guardian Claims			
SUPERVISING PHYSICIAN (If any)				

* If treatment was rendered under the Volunteer Firefighters' Benefit Law show as EMPLOYER the liable political subdivision and enter "X" here: ☐

HISTORY

1. HAVE YOU FILED A PREVIOUS REPORT SETTING FORTH A HISTORY OF THE INJURY?	YES ☒ NO ☐	IF "YES" ENTER DATE OF SUCH REPORT: AND COMPLETE ITEMS 3-10 BELOW.	IF "NO" COMPLETE ALL ITEMS BELOW.
A. STATE HOW INJURY OCCURRED AND GIVE SOURCE OF THIS INFORMATION. (IF CLAIM IS FOR OCCUPATIONAL DISEASE, INCLUDE OCCUPATIONAL HISTORY AND DATE OF ONSET OF RELATED SYMPTOMS.) Patient is a zinc miner who worked for St. Joes Resource Co. for 41 yrs. About 10-12 years ago he began experiencing shortness of breath on exertion, cough, chest pain, and wheezing. These symptoms have progressed and aggravated by present by a variety of environmental stimuli.			
B. WAS PATIENT PREVIOUSLY UNDER THE CARE OF ANOTHER DOCTOR FOR THIS INJURY?	YES ☐ NO ☒	IF "YES" ENTER HIS/HER NAME AND ADDRESS, AND REASON FOR TRANSFER IN ITEM 10.	C. WERE X-RAYS TAKEN? YES ☒ NO ☐
2. IF THERE IS ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE OR PHYSICAL IMPAIRMENT, DESCRIBE SPECIFICALLY: None			

DISABILITY

3. DESCRIBE NATURE AND EXTENT OF KNOWN OR REPORTED INJURY OR DISEASE WHEN EXAMINED, AND IF APPLICABLE, ANY CHANGE OF CONDITION SINCE LAST REPORT. The patient has pneumoconiosis which is most likely asbestosis and possibly silicosis. He has restrictive lung disease as a result of the pneumoconiosis. His airways have been affected by his workplace exposures also and he has most likely has a bronchospastic component to his disease as well.			
4. DATE(S) OF EXAMINATION ON WHICH THIS REPORT IS BASED	DATE OF YOUR FIRST TREATMENT	ARE YOU CONTINUING TREATMENT?	IF "YES" WHEN WILL PATIENT BE SEEN AGAIN?
2/23/89	2/23/89	YES	prn
5. DESCRIBE TREATMENT RENDERED AND PLANNED FUTURE TREATMENT. IF PATIENT WAS HOSPITALIZED, SO STATE AND GIVE NAME AND LOCATION OF HOSPITAL AND DATES OF HOSPITALIZATION. The patients pulmonary status was evaluated. A future treatment should include avoidance of dusts and irritants that may be toxic to the respiratory tract and aggressive treatment of any pulmonary infections.			
6. MAY THE INJURY RESULT IN PERMANENT RESTRICTION, TOTAL OR PARTIAL LOSS OF FUNCTION OF A PART OR MEMBER, OR PERMANENT FACIAL, HEAD OR NECK DISFIGUREMENT? IF "YES" DESCRIBE YES ☒ NO ☐ The lung disease is permanent and irreversible			
7. IS PATIENT WORKING?	IF "YES" ON WHAT DATE(S) DID PATIENT RESUME LIMITED WORK OF ANY KIND		IF "YES" CHECK ONE
YES ☐ NO ☒	DATE:		PARTIAL DISABILITY ☐
	RESUME REGULAR WORK		TOTAL DISABILITY ☒
	DATE:		
8. WAS THE OCCURRENCE DESCRIBED ABOVE (OR IN YOUR PREVIOUS REPORT WHICH GAVE THIS INFORMATION) THE COMPETENT PRODUCING CAUSE OF THE INJURY AND DISABILITY (IF ANY) SUSTAINED? YES ☒ NO ☐			

CAUSAL RELATION

REHABILITATION

9. (a) ANY FACTORS DELAYING RECOVERY? IF "YES" DESCRIBE	YES ☐ NO ☒
(b) IS MEDICAL AND/OR VOCATIONAL REHABILITATION INDICATED? IF "YES" GIVE REFERRAL DETAILS	YES ☐ NO ☒

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REMARKS

10. ENTER HERE ADDITIONAL PERTINENT INFORMATION, WORK LIMITATIONS, IF ANY, ETC. Because of his asbestos exposure the patient is at increased risk for lung cancer and mesothelioma. He should be examined annually with these possibilities in mind.

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If your testimony should be necessary in this case, please indicate the days of the week and time of day (AM or PM) most convenient to you for this purpose: Fridays, Mondays p.m.		* IF AUTHORIZATION FOR SPECIAL SERVICES IS REQUIRED, SEE ITEMS 4 AND 5 ON REVERSE.	
Dated 4/25/89	Typed or Printed Name of Attending Doctor Michael N. Lax, M.D.		Address 550 Harrison Ctr, Suite 300 Syracuse, NY 13202
VCB Rating Code PM	WCB Authorization No. 176488-S	Telephone No. 473-5422	Written Signature of Attending Doctor (Facsimile Not Accepted) Michael N. Lax, M.D.

A CHIROPRACTOR OR PODIATRIST FILING THIS REPORT CERTIFIES THAT THE INJURY DESCRIBED CONSISTS SOLELY OF A CONDITION(S) WHICH MAY FULLY BE TREATED AS DEFINED IN THE EDUCATION LAW AND, WHERE IT DOES NOT, HAS ADVISED THE INJURED PERSON TO CONSULT A PHYSICIAN OF HIS/HER CHOICE.