FILE NAME: RT Vanderbilt (RTV)

DATE: 1989 Feb 23

DOC#: RTV047

DOCUMENT DESCRIPTION: Medical Report of William Bowman Refering to Asbestos Exposure as an Increased Risk for Lung Cancer or Mesothelioma

ATTENDING DOCTOR: [redacted]

CHECK ONE: [X] INITIAL [ ] PROGRESS [ ] FINAL

CHECK TYPE OF DOCTOR: [X] 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	Balmat, NY	721-07-4499

INJURED PERSON	(First Name)	(Middle Initial)	(Last Name)	AGE	ADDRESS (Include Apt. No.)	TELEPHONE NO.
	William	Douglas	Bowman	63	Rt 3 Box 342 Gouverneur, NY 13642	287-0432
EMPLOYER*	St. Joes Resource Co				Balmat, 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: [ ]

1. HAVE YOU FILED A PREVIOUS REPORT SETTING FORTH A HISTORY OF THE INJURY? [ ] YES [X] NO — IF "YES" ENTER DATE OF SUCH REPORT: _____ AND COMPLETE ITEMS 3-10 BELOW. — IF "NO" COMPLETE ALL ITEMS BELOW.

HISTORY

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? [X] YES [ ] NO — IF "YES" ENTER HIS/HER NAME AND ADDRESS, AND REASON FOR TRANSFER IN ITEM 10.

C. WERE X-RAYS TAKEN? [X] YES [ ] NO

2. IF THERE IS ANY HISTORY OR EVIDENCE OF PRE-EXISTING INJURY, DISEASE OR PHYSICAL IMPAIRMENT, DESCRIBE SPECIFICALLY:

None

DIAGNOSIS

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 most likely has a bronchospastic component to his disease as well.

TREATMENT

4. DATE(S) OF EXAMINATION ON WHICH THIS REPORT IS BASED: 2/23/89 — DATE OF YOUR FIRST TREATMENT: 2/23/89 — ARE YOU CONTINUING TREATMENT? YES — IF "YES" WHEN WILL PATIENT BE SEEN AGAIN? 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 avoidence of dusts and irritants that may be toxic to the respiratory tract and agressive treatment of any pulmonary infections.

DISABILITY

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? [X] YES [ ] NO — IF "YES" DESCRIBE: The lung disease is permanent and irreversible

7. IS PATIENT WORKING? [ ] YES [X] NO — IF "YES" ON WHAT DATE(S) DID PATIENT: RESUME LIMITED WORK OF ANY KIND — DATE: ; RESUME REGULAR WORK — DATE: — IS PATIENT DISABLED? [X] YES [ ] NO — IF "YES" CHECK ONE: [ ] PARTIAL DISABILITY [X] TOTAL DISABILITY

CAUSAL RELATION

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? [X] YES [ ] NO

REHABILITATION

9. (a) ANY FACTORS DELAYING RECOVERY? IF "YES" DESCRIBE [ ] YES [X] NO

(b) IS MEDICAL AND/OR VOCATIONAL REHABILITATION INDICATED? IF "YES" GIVE REFERRAL DETAILS [ ] YES [X] NO

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REMARKS

10. ENTER HERE ADDITIONAL PERTINENT INFORMATION, WORK LIMITATIONS, IF ANY, ETC.

Because of his abbestos exposure the patient is at increased riskkfor lung cancer and mesothelioma. He should be examined annually with these possibilities in mind.

★ 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	Typed or Printed Name of Attending Doctor	Address
4/25/89	Michael B. Lax, M.D.	550 Harrison Ctr, Suite 300 Syracuse, NY 13202

WCB Rating Code	WCB Authorization No.	Telephone No.	Written Signature of Attending Doctor (Facsimile Not Accepted)
PM	176488-S	473-6422	Michael B Lax MD

A CHIROPRACTOR OR PODIATRIST FILING THIS REPORT CERTIFIES THAT THE INJURY DESCRIBED CONSISTS SOLELY OF A CONDITION(S) WHICH MAY LAWFULLY 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.

Combined C-4 / C-4B (5-86)

SEE REVERSE SIDE FOR IMPORTANT INSTRUCTIONS

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