Somerset Valley Urgent Care

470A US Highway 202/206
Bedminster, New Jersey 07921
www.SomersetValleyUrgentCare.com
(908) 781-7171

OFFICE USE ❑ **PHOTO ID VERIFIED BY SVUC STAFF**	INITIALS
FIRST NAME	
LAST NAME	
MIDDLE NAME	

SCBA Examination Consent

HOME PHONE #
CELL PHONE #
EMAIL

DATE OF BIRTH / /	SEX ❑ Male ❑ Female
ADDRESS	
ADDRESS 2	

CITY	STATE	ZIP

JOB TITLE / DEPARTMENT RANK
NAME EMPLOYER / DEPARTMENT / AGENCY
CONTACT PERSON / SAFETY OFFICER
CONTACT PHONE #

PRIMARY CARE PHYSICIAN
PHYSICIAN ADDRESS
PHYSICIAN PHONE

❑ I have been made aware of and was encouraged to avail myself to the benefit of the:

CAPTAIN BUSCIO COMPREHENSIVE FIREFIGHTER ASSESSMENT PROGRAM

http://cardiopulmonarydiagnostic.com

I voluntarily present for evaluation/examination and consent to the Somerset Valley Urgent Care (SVUC) physician and whomever they may designate as their assistant, associate, and patient care staff to assist. Based on the questionnaire and screening exam, an SVUC licensed medical provider will determine, to the best degree possible, if you are fit to utilize self-contained breathing apparatus (SCBA).

I acknowledge that no guarantee can be made as to my overall fitness based solely on this cursory SCBA evaluation/examination. I understand that in accordance with federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I must authorize my physician and/or the staff of SVUC to give copies of and/or discuss my condition/examination with individuals other than my primary care doctor or specialist before doing so. However, I understand that in the event of a critical episode or if I cannot give authorization due to the severity of my medical condition, the law stipulates that these rules may be waived.

I, _____ have read (or it has been read to me) and understand the above statement. I consent to an evaluation/examination and also authorize Somerset Valley Urgent Care, LLC to release information concerning this SCBA evaluation/examination to the following individual(s):

Name of Supervisor/Safety Officer (please print)	Employer/Department Name	Contact Number
Your Name (please print)	Your Signature	Date

Somerset Valley Urgent Care

Please check all that apply.			
☐	N95/100	☐	Full Face Neg Press
☐	PAPR	☐	SCBA
☐	½ Face Neg Press	☐	Airline Resp

To The Employer (i.e.; municipality, district, department, fire officer, supervisor):
Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To The Firefighter:
Can you read? ☐ Yes ☐ No

***NOTE:* To maintain your confidentiality, your "employer" (municipality, district, department, fire officer, supervisor) must not look at or review your answers, and your "employer" must tell you how to deliver or send this questionnaire to the Somerset Valley Urgent Care healthcare professional who will review it.**

PART A, Section I (Mandatory)

The following information must be provided by every employee who has been selected to use any type of respirator.

1.) Today's Date:

2.) Your Name:

3.) Your age *(to nearest year):*	4.) Sex: ☐ Male ☐ Female
5.) Your height: ft. in.	6.) Your weight: lbs.

7.) Your job title:

8.) Phone number you can be reached by healthcare professional who reviews this questionnaire *(including area code):*

9.) Best time to phone you at this number:

10.) Has your employer/department told you how to contact the healthcare professional who will review this questionnaire? ☐ Yes ☐ No

11.) Check the type of respirator you will use (you can check more than one category):
- ☐ N,R or P disposable respirator (filter-mask, non-cartridge type only)
- ☒ Other type (example: half-or full-face piece type, powered air purifying, supplied-air, self-contained breathing apparatus)

12.) Have you worn a respirator? ☐ Yes ☐ No If yes, what types(s):

Part A, Section II (Mandatory)

Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator. Please check Yes or No.

1.) Do you currently smoke tobacco, or have you smoked tobacco in the last month?..... ☐Yes ☐No

2.) Have you ever had any of the following conditions?

a.) Seizures (fits)…… ☐Yes ☐No
b.) Diabetes (sugar disease)…… ☐Yes ☐No
c.) Allergic reactions that interfere with your breathing…… ☐Yes ☐No
d.) Claustrophobia (fear of closed-in places)…… ☐Yes ☐No
e.) Trouble smelling odors…… ☐Yes ☐No

3.) Have you ever had any of the following pulmonary or lung problems?

a.) Asbestosis…….. ☐Yes ☐No
b.) Asthma……... ☐Yes ☐No
c.) Chronic bronchitis…….. ☐Yes ☐No
d.) Emphysema…..……... ☐Yes ☐No
e.) Pneumonia…….. ☐Yes ☐No
f.) Tuberculosis……... ☐Yes ☐No
g.) Silicosis…….. ☐Yes ☐No
h.) Pneumothorax (collapsed lung)…….. ☐Yes ☐No
i.) Lung cancer……... ☐Yes ☐No
j.) Broken ribs……... ☐Yes ☐No
k.) Any chest injuries or surgeries…… ☐Yes ☐No
l.) Any other lung problem that you've been told about…… ☐Yes ☐No

4.) Do you currently have any of the following symptoms of pulmonary or lung illness?

a.) Shortness of breath…… ☐Yes ☐No
b.) Shortness of breath when walking fast on level ground or walking up a slight hill or incline.. ☐Yes ☐No
c.) Shortness of breath when walking with other people at an ordinary pace on level ground..…. ☐Yes ☐No
d.) Have to stop for breath when walking at your own pace on level ground…….…… ☐Yes ☐No
e.) Shortness of breath when washing or dressing yourself……..……..…… ☐Yes ☐No
f.) Shortness of breath that interferes with your job……...…. ☐Yes ☐No
g.) Coughing that produces phlegm (thick sputum)……..……...…. ☐Yes ☐No
h.) Coughing that wakes you early in the morning……..…. ☐Yes ☐No
i.) Coughing that occurs mostly when you are lying down…… ☐Yes ☐No
j.) Coughing up blood in the last month……..…. ☐Yes ☐No
k.) Wheezing…… ☐Yes ☐No
l.) Wheezing that interferes with your job…….. ☐Yes ☐No
m.) Chest pain when you breathe deeply…..…….. ☐Yes ☐No
n.) Any other symptoms you think may be related to lung problems…… ☐Yes ☐No

5.) Have you ever had any of the following cardiovascular or heart problems?

a.) Heart attack…… ☐Yes ☐No
b.) Stroke…… ☐Yes ☐No
c.) Angina…… ☐Yes ☐No
d.) Heart failure…… ☐Yes ☐No
e.) Swelling in your legs or feet (not caused by walking)……..…… ☐Yes ☐No
f.) Heart arrhythmia (heart beating irregularly)…….. ☐Yes ☐No
g.) High blood pressure……..…….…… ☐Yes ☐No
h.) Any other heart problem that you've been told about..……...…. ☐Yes ☐No

Part A, Section II (Continued)

6.) Have you ever had any of the following cardiovascular or heart symptoms?

a.) Frequent pain or tightness in your chest ☐Yes ☐No
b.) Pain or tightness in your chest during physical activity ☐Yes ☐No
c.) Pain or tightness in your chest that interferes with your job ☐Yes ☐No
d.) In the past two years, have you noticed your heart skipping or missing a beat ☐Yes ☐No
e.) Heartburn or indigestion that is not related to eating ☐Yes ☐No
f.) Any other symptoms that you think may be related to heart or circulation problems ☐Yes ☐No

7.) Do you currently take medication for any of the following problems?

a.) Breathing or lung problems ☐Yes ☐No
b.) Heart trouble ☐Yes ☐No
c.) Blood pressure ☐Yes ☐No
d.) Seizures (fits) ☐Yes ☐No

8.) If you used a respirator, have you ever had any of the following problems? If you have never used a respirator, check here ☐ and go to question 9.

a.) Eye irritation ☐Yes ☐No
b.) Skin allergies or rashes ☐Yes ☐No
c.) Anxiety ☐Yes ☐No
d.) General weakness or fatigue ☐Yes ☐No
e.) Any other problem that interferes with your use of a respirator ☐Yes ☐No

9.) Would you like to talk to the healthcare professional who will review this questionnaire regarding your answers ☐Yes ☐No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-face piece respirator or a self-contained breathing apparatus (SCBA).

10.) Have you ever lost vision in either eye (temporarily or permanently)? ☐Yes ☐No

11.) Do you currently have any of the following vision problems?

a.) Wear contact lenses ☐Yes ☐No
b.) Wear glasses ☐Yes ☐No
c.) Color blind ☐Yes ☐No
d.) Any other eye or vision problems ☐Yes ☐No

12.) Have you ever had an injury to your ears, including a broken ear drum? ☐Yes ☐No

13.) Do you currently have any of the following hearing problems?

a.) Difficulty hearing ☐Yes ☐No
b.) Wear a hearing aid ☐Yes ☐No
c.) Any other hearing or ear problem ☐Yes ☐No

14.) Have you ever had a back injury? ☐Yes ☐No

15.) Do you currently have any of the following musculoskeletal problems?

a.) Weakness in any of your arms, hands, legs, or feet ☐Yes ☐No
b.) Back pain ☐Yes ☐No
c.) Difficulty fully moving your arms and legs ☐Yes ☐No
d.) Pain or stiffness when you lean forward or backward at the waist ☐Yes ☐No
e.) Difficulty fully moving your head up or down ☐Yes ☐No
f.) Difficulty full moving your head side to side ☐Yes ☐No
g.) Difficulty bending at your knees ☐Yes ☐No
h.) Difficulty squatting to the ground ☐Yes ☐No
i.) Climbing a flight of stairs or a ladder carrying more than 25 lbs ☐Yes ☐No
j.) Any other muscle or skeletal problem that interferes with using a respirator ☐Yes ☐No

Part B

1.) At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes or dust), or have you come into skin contact with hazardous materials?.... ☐Yes ☐No

If yes, name the chemicals if you know them:

2.) Have you ever worked with any of the materials, or under any of the conditions listed below?

a.) Absestos…….…… ☐Yes ☐No
b.) Silica (e.g., in sandblasting)…… ☐Yes ☐No
c.) Tungsten/cobalt (e.g., grinding or welding this material)……..…… ☐Yes ☐No
d.) Beryllium…....……..…. ☐Yes ☐No
e.) Aluminum…… ☐Yes ☐No
f.) Coal (e.g., mining)…… ☐Yes ☐No
g.) Iron…… ☐Yes ☐No
h.) Tin…… ☐Yes ☐No
i.) Dusty environments…… ☐Yes ☐No
j.) Any other hazardous exposures (if yes, describe the exposures)…… ☐Yes ☐No

3.) List any second jobs or side businesses you have:

4.) List your previous occupations:

5.) List your current and previous hobbies:

6.) Have you been in the military services?..... ☐Yes ☐No

If yes, were you exposed to biological or chemical agents (either in training or combat)?..... ☐Yes ☐No

7.) Have you ever worked on a HAZMAT team?..... ☐Yes ☐No

8.) Other than medications for breathing and lung problems, heart trouble, blood pressure and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications?..... ☐Yes ☐No

If yes, name the medications if you know them:

Part B (Continued)

9.) Will you be using any of the following items with your respirator(s)?

a.) HEPA filters…… ☐ Yes ☐ No
b.) Canisters (for example, gas masks)..…… ☐ Yes ☐ No
c.) Cartridges…… ☐ Yes ☐ No

10.) How often are you expected to use the respirator(s) (check all that apply)?

a.) Escape only (no rescue)…… ☐ Yes ☐ No
b.) Emergency rescue only…… ☐ Yes ☐ No
c.) Less than 5 hours per week..…… ☐ Yes ☐ No
d.) Less than 2 hours per day…… ☐ Yes ☐ No
e.) 2 to 4 hours per day…… ☐ Yes ☐ No
f.) Over 4 hours per day…… ☐ Yes ☐ No

11.) During the period you are using the respirator(s), is your work effort (check one):

☐ Light ☐ Moderate ☒ Heavy

12.) When you are using your respirator, will you be wearing protective clothing and/or equipment (other than the respirator)..... ☐ Yes ☐ No

If yes, describe the protective clothing and/or equipment:

13.) Will you be working under hot conditions (temperature exceeding 77 degrees)?..... ☐ Yes ☐ No

14.) Will you be working under humid conditions?..... ☐ Yes ☐ No

15.) Describe the work you will be doing while using your respirator(s):

16.) Describe any special or hazardous conditions you might encounter when you are using your respirator(s) (for example, confined spaces, life-threatening gases):

Signature:	Date:
Date of birth:	ID:

Department's Information

Type of respirator:
Weight of respirator:
Expected physical work effort when respirator is in use:
Additional protective equipment to be worn:
Please note any extreme of temperature or humidity:

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PATIENT NAME:	DATE OF BIRTH:	REVIEWED BY:	EXAM DATE:

Please complete the following questions before your SCBA examination – leave no blank spaces:

	Yes	No	Not Sure		Yes	No	Not Sure
Frequent Headaches	❑	❑	❑	Bladder Infections	❑	❑	❑
Eye or Ear Infections	❑	❑	❑	Frequent Urination	❑	❑	❑
Hearing Problem or Hearing Loss	❑	❑	❑	Broken Bones	❑	❑	❑
Visual Problem or Eye Disease	❑	❑	❑	Back Injury, Sprains or Surgery	❑	❑	❑
Throat Trouble	❑	❑	❑	Ruptured Disc in Back	❑	❑	❑
Sinus Trouble	❑	❑	❑	Chronic Back Pain	❑	❑	❑
Nose Bleeds	❑	❑	❑	Arthritis	❑	❑	❑
Thyroid Problems	❑	❑	❑	Deformities of Joints	❑	❑	❑
Frequent Colds	❑	❑	❑	Deformities of Bones	❑	❑	❑
Lumps or Tumors in Neck	❑	❑	❑	Missing Fingers or Toes	❑	❑	❑
Asthma	❑	❑	❑	Foot Problems	❑	❑	❑
Pneumonia	❑	❑	❑	Skin Rashes	❑	❑	❑
Pleurisy	❑	❑	❑	Skin Tumors	❑	❑	❑
Spitting up Blood	❑	❑	❑	Head Injury	❑	❑	❑
Coughing up Blood	❑	❑	❑	Epilepsy or Fits	❑	❑	❑
Chronic Cough	❑	❑	❑	Frequent Dizziness	❑	❑	❑
Lung Trouble	❑	❑	❑	Paralysis	❑	❑	❑
Tuberculosis	❑	❑	❑	Loss of Memory	❑	❑	❑
Shortness of Breath	❑	❑	❑	Diabetes or High Sugar	❑	❑	❑
Chest Pains	❑	❑	❑	High Cholesterol	❑	❑	❑
Rheumatic Fever	❑	❑	❑	Sugar in Urine	❑	❑	❑
Heart Murmur	❑	❑	❑	Allergies	❑	❑	❑
Swelling of Ankles	❑	❑	❑	Allergic reaction to Food	❑	❑	❑
Low Blood Pressure	❑	❑	❑	Allergic reaction to Drugs	❑	❑	❑
Stomach Trouble	❑	❑	❑	Anemia	❑	❑	❑
Heartburn	❑	❑	❑	Easy Bruising	❑	❑	❑
Vomiting Blood	❑	❑	❑	Polio	❑	❑	❑
Black Bowel Movements	❑	❑	❑	Recent Weight Loss	❑	❑	❑
Blood in Stools	❑	❑	❑	Recent Weight Gain	❑	❑	❑
Frequent Diarrhea	❑	❑	❑	Fatigue	❑	❑	❑
Abdominal Pains	❑	❑	❑	Depression	❑	❑	❑
Gallbladder Trouble	❑	❑	❑	Anxiety or Panic Attacks	❑	❑	❑
Liver Trouble	❑	❑	❑	Change in Activity Level	❑	❑	❑
Hepatitis or Jaundice	❑	❑	❑	High Blood Pressure	❑	❑	❑
Piles, Hemorrhoids	❑	❑	❑	Chronic Bronchitis	❑	❑	❑
Tropical Disease or Worms	❑	❑	❑	Muscle Pain	❑	❑	❑
Hernia or Rupture	❑	❑	❑	Sleeping Problems	❑	❑	❑
Kidney Trouble	❑	❑	❑	Breast Lumps	❑	❑	❑
Kidney Stones	❑	❑	❑	Loss of Consciousness	❑	❑	❑
Blood in Urine	❑	❑	❑	Excessive Thirst	❑	❑	❑

** FOLLOWING TO BE COMPLETED BY HEALTH CARE STAFF/PROVIDER **

BP:	BP (Repeat):	PULSE:	RESPIRATIONS:	SAO2:	TEMPERATURE:	HEIGHT:	WEIGHT:

VISUAL ACUITY: WITH CORRECTION: ❑ YES ❑NO	RIGHT EYE:	LEFT EYE:	BOTH EYES:	SHIHARA COLOR:	FIELD OF VISION:

MEDICATIONS: ❑ None	DOSE	FREQ

SOCIAL HISTORY: ❑ Never Smoker (<100 in lifetime)
Packs per day: Yr(s) Smoked: _____ Yr Quit:_____
❑ 2nd Hand ❑ Cigars ❑ Chew or snuff
Alcohol? ❑ No ❑ Quit ❑ Occasional ❑ # Per Day:
Street /Unprescribed Drugs? ❑ Yes ❑ No
✈Travel Risk / Exposure? ❑ Yes ❑ No

PAST MEDICAL HISTORY: ❑ None
❑ CAD ❑ HTN ❑ DM ❑ Asthma ❑ COPD ❑ CA

SURGERIES: ❑ None	DATE(s)

ALLERGIES: ❑ NKDA	REACTION

FAMILY MEDICAL HISTORY: ❑ None	RELATION

NORMAL	SYSTEM	ABNORMAL COMMENTS / FINDING
	HEAD	
	EYES	
	ENT	
	NECK	
	CHEST / BREASTS	
	LUNGS	
	HEART	
	ABDOMEN	
N/A	RECTAL / GENITALIA	
	EXTREMITIES	
	SPINE	
	NEURO	
	SKIN	
	PSYCH	

FITNESS DETERMINATION (based on the SCBA and exam questionnaires as well as a screening exam):

- ❑ This firefighter is believed to be physically able to use a respirator.
- ❑ This firefighter is **NOT believed to be physically able** to use a respirator.
- ❑ There is insufficient information at this time to determine if this firefighter can use a respirator.
- ➢ Follow-up advised with: ❑ Pulmonologist ❑ Cardiologist ❑ Other:

NAME OF EXAMINING PROVIDER:	EXAMINING PROVIDER SIGNATURE:	DATE:

Please accept Dom's gift to you this year and every year.

Don't wait, schedule an appointment today for the "Gift from Captain Buscio"

CARDIO PULMONARY DIAGNOSTIC

Newark Airport Office
973-596-1200

Secaucus Office
201-216-3055

Paramus Office
201-556-1225

Lakewood Office
732-987-9676

CARDIO PULMONARY DIAGNOSTIC
Specialists in Diseases of the Chest

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1265 Paterson Plank Road, Suite 2D - 2E
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Tel: 201.216.3055

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Tel: 201.556.1225

1255 Route 70, Suite 12-S
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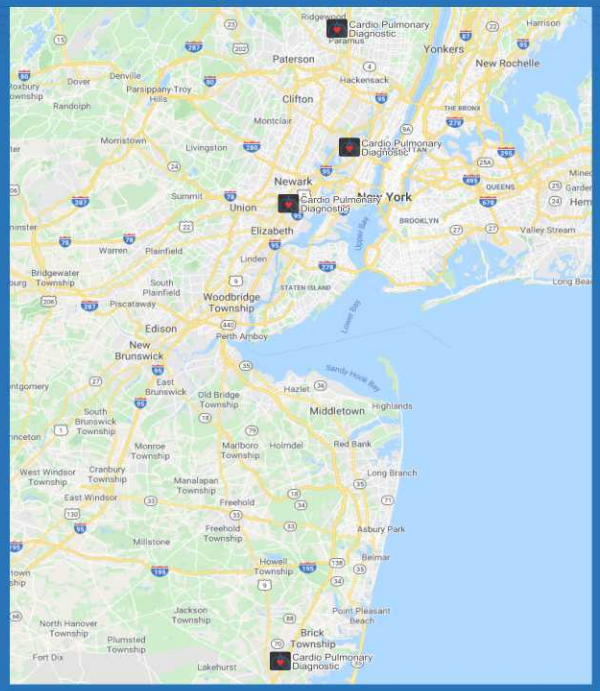
www.cardiopulmonarydiagnostic.com



SPECIAL THANKS TO...

New Jersey Firefighters Mutual Benevolent Association.
1447 Campbell St.
Rahway, New Jersey 07065

New Jersey State Policemen's Benevolent Association Inc.
158 Main Street
Woodbridge, New Jersey 07095

Professional Firefighters Association of New Jersey
24 W. Lafayette Street
Trenton, NJ 08608

FOR YOUR DEDICATED SUPPORT

CARDIO PULMONARY DIAGNOSTIC
Specialists in Diseases of the Chest

A Gift from Captain Buscio

A Message from Donna Buscio

Dear Friends,

My late husband Captain Dominick Buscio was a dedicated fire captain of the Jersey City Fire Department. Dom was a wonderful husband, father, brother and son to his family, and a true friend to all who knew him. At the age of 39, his life was unexpectedly taken when he suffered a heart attack during our ski vacation. Dom was the picture of health. In fact, the results of a complete physical he had only 19 months before his death were normal, except for the presence of a moderately high cholesterol level. Since he was found to be healthy at that time, he decided not to return for his annual physical the following year. While many people his age make the decision not to seek regular checkups, in his case, it resulted in an inconceivable loss to all of us.

I am sharing our experience with others because I have found that my husband's death was not a rarity. Heart attacks are the largest single killer of firefighters. For that very reason, I created the program "A Gift from Captain Buscio," which began in Jersey City and now spans across the State of New Jersey to offer strictly confidential, comprehensive cardiovascular and pulmonary evaluations to all firefighters, police, and first responders. These annual examinations are provided by board certified cardiologists and pulmonologists from Cardio Pulmonary Diagnostic .

My intention is not to instill anxiety. On the contrary, it's to provide an opportunity for peace of mind. I'm quite certain that this program would have had Dom's full support, given the current limited opportunities for firefighters to obtain physicals.

For me, this program, which was founded in Dom's memory, is an attempt to keep your occupational risk limited to fighting fires, reducing crime and providing aid to those in need.

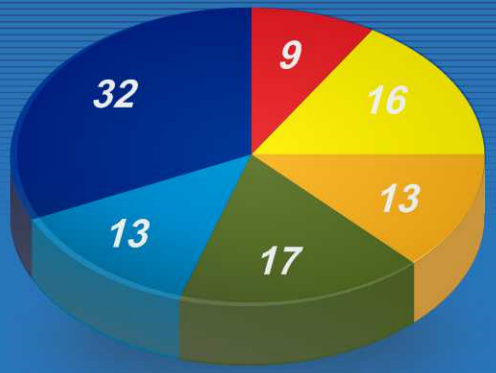
This pamphlet provides you with details on the program and how you may benefit from it. If you have any questions or concerns regarding information other than what is available on the captainsgift.com web site, please contact me at dbuscio@captainsgift.com.

Sincerely,

Donna Buscio
www.CaptainsGift.com

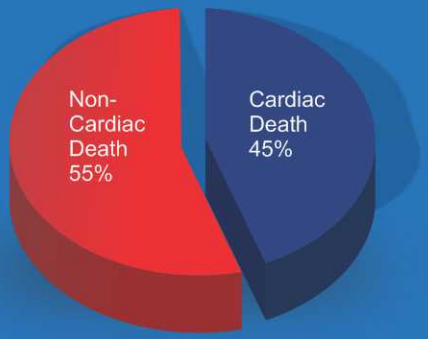
STATISTICS TELL THE STORY

Activity During Cardiac Event



- EMS/Non Fire
- Fire Station
- Alarm Response
- Alarm Return
- Physical Training
- Fire Suppression

Nearly half of all on-duty firefighter deaths are due to cardiac cause



New England Journal of Medicine
"Emergency Duties and Deaths from Heart Disease among Firefighters in the United States"

How "A Gift from Captain Buscio" Works

All current and retired firefighters, police, and emergency responders, and their colleagues are invited to participate in the program throughout the State of New Jersey. They will then have an opportunity to receive confidential comprehensive Cardiovascular and Pulmonary medical evaluations. The medical facility will take the responsibility of billing the Participant's insurance provider (note that the doctors and/or facility may be an out of network provider). These annual examinations are provided by Cardio Pulmonary Diagnostic and their network of providers.

The dedicated team of Providers and Board-Certified Cardiologists and Pulmonologists have generously offered firefighters, police, and emergency responders medical care since 2001 that is specific to their profession.

Testing will be provided based upon each participant's medical history. Testing may include laboratory, x-ray, pulmonary functions testing, cardiovascular screening and sleep study. Upon completion the participant will be provided with a medical report which they can use at their discretion.

All visits will be scheduled by appointment. Please be prepared to answer questions regarding your personal, family, medical and surgical history, your primary care physicians address and contact number. Bring any recent testing or examination results from another healthcare provider and a list of all medications that you may currently be taking. Fasting the previous night is required for blood work, which is part of the evaluation.

Bring your work ID and/or driver's license along with your insurance card.

To schedule an appointment, call:

CARDIO PULMONARY DIAGNOSTIC
Newark: 973-596-1200
Secaucus: 201-216-3055
Paramus: 201-556-1225
Lakewood: 732-987-9676