

FORM TO SAY “YES’ OR “NO” TO CHOLINESTERASE BLOOD TESTING

Please ask about anything on this form that you do not understand before deciding to have or not to have the cholinesterase blood tests

You are here because you handle organophosphate and N-methyl-carbamate pesticides with the words “DANGER” or “WARNING” on the label. Washington state safety rules give you the choice to have your blood cholinesterase tested or not.

Cholinesterase helps to control your body’s nervous system. Overexposure to organophosphate and N-methyl-carbamate pesticides can lower your cholinesterase and you can become sick.

Only you can decide to have the blood tests or not. It is against the law for your employer to interfere with your decision. After reading this form completely, sign your name in the space saying if you will or will not get the blood tests.

WHAT HAPPENS AND WHY

To get these blood tests, you must get a test when you have not handled these pesticides for a while (baseline). About 30 days after you start handling organophosphate and N-methyl-carbamate pesticides, you may get another test (follow-up). How often you are tested depends on how many hours you handle these pesticides in each 30 day period.

- The purpose of these tests is to detect overexposure and help prevent pesticide illness.
- Your employer must make sure that you can get the blood tests when tests are required but only if you choose to have blood tests.
- You pay nothing for the blood tests.
- Your employer will pay for all costs.

Every time you get the blood test a medical worker will take about 2 tablespoons of blood from a vein in your arm. This blood will go into two small tubes. The medical worker will use a sterile needle to take the blood. This part takes about 5 minutes. Then you will wear a Band-Aid on your arm for a few hours.

TEST RESULTS

Your follow-up test results could show that you have had too much pesticide exposure. Or, they could show that you are fine and you can continue to work as usual. You and your employer will be told what the test results are. If your cholinesterase level has dropped greatly you may need to stop handling organophosphate and N-methyl-carbamate pesticides until your cholinesterase returns to its usual level (baseline). Blood tests can show when it is safe for you to return to handling these pesticides. **The rule protects your job if you are temporarily removed from handling organophosphate and N-methyl-carbamate pesticides.**

The Department of Health and the Department of Labor and Industries in Washington State will also get the test results.

RISKS

- The pain of a needlestick
- You might get a bruise
- You could feel a little dizzy.
- Rarely, someone gets an infection.

BENEFITS

- Tell if your pesticide handling practices and equipment are protecting you
- Tell if you have had too much exposure to these pesticides
- Avoid sickness from overexposure
- Help you and your employer make the workplace safer

YES, I CHOOSE TO GET THE BLOOD TESTS

I have read this form (or had it read to me) and talked about the blood tests with the medical worker. I CHOOSE TO GET THE CHOLINESTERASE BLOOD TESTS.

By agreeing to thee blood tests I also agree to allow (provider) _____ AND/OR the Department of Labor & Industries to share my cholinesterase test results with my employer _____ for a period not longer than 1 year from the signature date.

Patient Signature	Printed Name	Date
Witness Signature	Printed Name	Date

NO, I CHOOSE NOT TO GET THE BLOOD TESTS

I have read this form (or had it read to me) and talked about the blood tests with the medical worker. I understand the risks and benefits of cholinesterase testing and CHOOSE NOT TO GET THE CHOLINESTERASE BLOOD TESTS. I also understand that I can change my mind at any time and get the blood tests without cost.

Patient Signature	Printed Name	Date
Witness Signature	Printed Name	Date

Complete this section only if form is read to participant

I confirm that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the participant. The participant freely consented to participate in the screening program.

Signature of Witness	Printed Name	Date
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