Report of Arterial Blood Gas Study

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U.S. Department of Labor
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

This report is authorized by law (30 USC 901 et. seq). The results of this study will aid in determining the miner's eligibility for black lung benefits. This method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974, and OMB Circular No. 108.

OMB No. 1240-0023
Expires: 08-31-2020

Instructions: Summarized below are the procedures to be followed in administering this test. The arterial blood gas study shall initially be administered at rest and in a sitting position. **If the results of the test at rest are not within the values indicated on the applicable table shown on the reverse side of this form, an exercise blood gas study shall be offered to the miner unless medically contraindicated. *If an exercise blood gas test is administered, blood shall be drawn during exercise.** Complete instructions for administration of this test and table of values may be found in 20 CFR Part 718, Subpart B, 718.105, and appendix C.

1. Name of Miner (First, middle, last)

2. DOL's Case ID Number

3. Date of Test (mm/dd/yyyy)

4. Miner's:
- Age
- Height (inches and in stocking feet – no shoes)
- Weight (lbs.)

5. Altitude: (Check one)
- ☐ 0 to 2999 feet above sea level
- ☐ 3000 to 5999 feet above sea level
- ☐ 6000 feet or more above sea level

6. Barometric Pressure

(Equipment Temperature) ^{0}C

7. Site of Puncture: **Indwelling line:** **Single stick:**

8. Miner's last date of acute respiratory or cardiac illness (mm/dd/yyyy):

a.

	Time Sample Drawn	Iced Yes	Iced No	Time Sample Analyzed
Rest:		☐	☐	
During Exercise:*		☐	☐	

b. Miner's pulse rate at time sample drawn:

Rest: *During Exercise

c. Was equipment calibrated before and after each test?

☐ Yes ☐ No

d. Type of exercise and duration:*

9.

Test Results	Predicted Normal Range	Observed Values: Resting	Observed Values: Exercise if Administered*
pCO_2(mmHg)			
PO_2 (mmHg)			
pH			

***Is the exercise portion of this study medically contraindicated? If YES, for what reason?** ☐ Yes ☐ No

10. Additional Comments:

11 a. Facility where test performed:

11 b. Provider Number :

12. Print or type name of technician performing the study:

13. Print or type the name of physician supervising the test:

14. Physician's Signature: I certify that the information furnished is correct and am aware that my signature attests to the accuracy of the results reported. I am also aware that any person who willfully makes any false or misleading statement or representation in support of an application for benefits shall be guilty of a misdemeanor under 30 USC 941 and, on conviction, subject to a fine of up to $1000, or imprisonment for up to one year, or both.

Signature: Date:

Blood Gas Tables

The following tables set forth the values to be applied in determining whether total disability may be established in accordance with the criteria contained in 20 CFR 718.

(1) For arterial blood gas studies performed at test sites up to 2,999 feet above sea level:

Arterial pCO_2 (mmHg)	Arterial pO_2 equal to or less than (mmHg)
25 or below	75
26	74
27	73
28	72
29	71
30	70
31	69
32	68
33	67
34	66
35	65
36	64
37	63
38	62
39	61
40-49	60
50 and Above	(1)

[1] Any value

(2) For arterial blood gas studies performed at test sites 3,000 to 5,999 feet above sea level:

Arterial pCO_2 (mmHg)	Arterial pO_2 equal to or less than (mmHg)
25 or below	70
26	69
27	68
28	67
29	66
30	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40-49	55
50 and Above	(2)

[2] Any value

(3) For arterial blood gas studies performed at test sites 6,000 feet or more above sea level:

Arterial pCO_2 (mmHg)	Arterial pO_2 equal to or less than (mmHg)
25	65
26	64
27	63
28	62
29	61
30	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40-49	50
50 and Above	(3)

[3] Any value

Public Burden Statement

We estimate that it will take an average of 15 minutes to complete this information collection including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the information. If you have any comments regarding this burden estimate or any other aspect of this information collection, including suggestions for reducing this burden, send them to the Division of Coal Mine Workers' Compensation, U.S. Department of Labor, Room N-3464, 200 Constitution Avenue, NW, Washington, DC. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

PRIVACY ACT NOTICE

The following information is provided in accordance with the Privacy Act of 1974, 5 USC 552a. (1) Submission of this information is required under the Black Lung Benefits Act. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, including potentially liable coal mine operators and their insurance carriers; medical professionals in obtaining medical services or evaluations; contractors providing automated data processing services to the Department of Labor; representatives of the parties to the claim; and federal, state or local agencies in obtaining information about eligibility for benefits.. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (5) This information is included in a System of Records, DOL/OWCP-2, published at 81 Federal Register 25765, 25858 (April 29, 2016), or as updated and republished.

NOTICE

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims examiner to ask about this assistance.

Note: Persons are not required to complete this collection of information unless it displays a currently valid OMB control number.