North Dakota Workforce Safety & Insurance

HEART CONDITION QUESTIONNAIRE

CLAIMS DIVISION
SFN 60952 (03/2025)

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Fraud and Safety Hotline 800-243-3331
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SECTION 1 – *Claim information*

Claim number	Injured employee's (First name)	(Last name)

SECTION 2 – *Provide the names and address of all medical doctors or other healthcare professionals who have treated this condition*

Facility name		Time frame	
Address			
City	State	ZIP code	Telephone number

Facility name		Time frame	
Address			
City	State	ZIP code	Telephone number

Provide any additional facility names, addresses and telephone numbers on the back or separate sheet of paper.

SECTION 3 – *Have you ever had the following*

Health conditions

Disorders	No	Yes	Don't know	Treating MD/Facility/Year	Is this still a problem?
Coronary artery disease	☐	☐	☐		☐ Yes ☐ No
Hypertension	☐	☐	☐		☐ Yes ☐ No
Diabetes	☐	☐	☐		☐ Yes ☐ No
Congenital condition	☐	☐	☐		☐ Yes ☐ No
High cholesterol	☐	☐	☐		☐ Yes ☐ No
Congestive heart failure	☐	☐	☐		☐ Yes ☐ No
Pulmonary hypertension	☐	☐	☐		☐ Yes ☐ No
Pericardial disease/pericarditis	☐	☐	☐		☐ Yes ☐ No
Myocardial infarction (heart attack)	☐	☐	☐		☐ Yes ☐ No
Lead exposure	☐	☐	☐		☐ Yes ☐ No
Carbon monoxide exposure	☐	☐	☐		☐ Yes ☐ No
Thyroid disease	☐	☐	☐		☐ Yes ☐ No
Cardiomyopathy	☐	☐	☐		☐ Yes ☐ No
Peripheral vascular disease	☐	☐	☐		☐ Yes ☐ No
Pulmonary embolism/DVT	☐	☐	☐		☐ Yes ☐ No
Stroke	☐	☐	☐		☐ Yes ☐ No
Heart valve disorder	☐	☐	☐		☐ Yes ☐ No
Cancer/radiation	☐	☐	☐		☐ Yes ☐ No
Chest pain or pressure	☐	☐	☐		☐ Yes ☐ No
Chest pain with exertion	☐	☐	☐		☐ Yes ☐ No
Shortness of breath	☐	☐	☐		☐ Yes ☐ No
Fainting/light headedness	☐	☐	☐		☐ Yes ☐ No
Methylene exposure	☐	☐	☐		☐ Yes ☐ No
Exposure to other chemicals, solvents, and toxins	☐	☐	☐		☐ Yes ☐ No
Irregular/rapid heartbeat	☐	☐	☐		☐ Yes ☐ No
Bleeding/clotting disorder	☐	☐	☐		☐ Yes ☐ No
Additional information					

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Claim number	Injured employee's (First name)	(Last name)

Diagnostic tests			
Electrocardiogram abnormalities	☐ Yes ☐ No	High serum LDL cholesterol	☐ Yes ☐ No
Low serum HDL cholesterol	☐ Yes ☐ No	Cardiac catheterization	☐ Yes ☐ No
Echocardiogram	☐ Yes ☐ No	Holter monitor	☐ Yes ☐ No
MUGA scan	☐ Yes ☐ No	Angiography	☐ Yes ☐ No
Additional information			
Do you have a history of exposure to secondhand smoke?	☐ Yes ☐ No		
Comments			
Do you use tobacco products currently?	☐ Yes ☐ No		
Comments			
Have you used tobacco products in the past?	☐ Yes ☐ No		
Comments			

Current and past medications for the last three years

Drug/Dose/Frequency	Reason prescribed and when did you start/end	Prescribing doctor	Side effects

When did you become aware your condition was related to your work?

SECTION 4 – *Release of information/fraud warning/signature*

Release of information

I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records. In addition, I authorize any education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g.

This authorization lasts for 1 year after the date signed unless I enter a different expiration date here _____.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

WSI is exempt from HIPAA regulations. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

Fraud warning

Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with WSI, including injured employees, employers, medical providers, and attorneys.

Signature

By signing this form, I acknowledge that I have read and understand the release of information and fraud warning. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

Injured employee's signature	**Date**

SECTION 5 – *Additional information or comments*