## IAQ REFERRAL FORM

<table>
<thead>
<tr>
<th>Name:</th>
<th>Name of Supervisor:</th>
<th>Date of Request:</th>
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<tr>
<th>Employee Phone:</th>
<th>Department/Faculty:</th>
<th>Facility Manager name:</th>
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<tr>
<th>Employee Email:</th>
<th>Building/Location/Room#:</th>
<th>Safety Committee notified</th>
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- Yes
- No

### Please provide the following background information on the nature of your concern:

#### What symptoms are you experiencing?

- Difficulty in concentrating
- Noticeable odors
- Dry or sore throat
- Dizziness
- Sinus congestion
- Aching joints
- Headache
- Sneezing
- Back pain
- Nausea
- Shortness of breath
- Skin irritation
- Fatigue/drowsiness
- Chest tightness
- Eye irritation
- Other (specify):

#### What are the conditions when you experience these symptoms?

- Temperature too hot
- Noticeable odors
- Noticeable odors
- Dry or sore throat
- Temperature too cold
- Noticeable odors
- Noticeable odors
- Back pain
- Other (specify):

- Noisy Environment
- Poor Lighting

#### What time of day do you experience the problem?  
- Morning
- Afternoon
- Evening
- All day

#### Please indicate specific day(s) and times of the week that you experience the above symptoms?

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<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
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#### Do you have any allergies that may account for any of the listed symptoms?

- Yes
- No

If yes, please describe:

#### When does the problem seem to dissipate?

#### Does any of your tasks produce dust, odor or use any toxic substances?

- Yes
- No

If yes, please describe:

### Please send the completed form to:

Sonam Uppal – Occupational Hygiene Advisor  
Email: sonam.uppal@ubc.ca