THE UNIVERSITY OF BRITISH COLUMBIA

Safety & Risk Services
336-2389 Health Sciences Mall
Vancouver, BC V6T 1Z3
www.srs.ubc.ca

IAQ REFERRAL FORM

Name:	Name of Supervisor:	Date of Request:
Employee Phone:	Department/Faculty:	Facility Manager name:
Employee Email:	Building/Location/Room#:	Safety Committee notified ❑ 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	❑	Noisy Environment	❑
Temperature too cold	❑	Poor Lighting	❑

Other (specify) :

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?

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

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