FLORIDA DEPARTMENT OF HEALTH

Merlin Case #:

Carbon Monoxide Poisoning Reporting Form

Exposed Person Demographic Information

Name: _____ _____ _____ **Date of Birth**: ____/_____/_____
First M.I. Last mm/dd/yyyy

Street address: _____

City: _____ County: _____ Zip:_____

Telephone #: Home: _____ Work: _____ Other: _____

Name of Employer OR School: _____

Gender: ☐ Male ☐ Female

Race/Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Native American ☐ Hispanic ☐ Other _____

Exposure/Incident Information

Date and time of incident (mm/dd/yyyy): _____/_____/_____ Time: _____:____

Brief description of incident: _____

_____

Total # of people exposed: ____ Relation among exposed: _____

Poisoning intent: ☐ Intentional CO Poisoning ☐ Unintentional CO Poisoning

Type of exposure: ☐ Generator ☐ Automobile/RV ☐ Boat ☐ Kerosene/gas space heater ☐ Power Tools (include mower) ☐ Fuel Burning Appliances (fixed stove/boiler/furnace) ☐ Portable fuel burning grill/stove ☐ Other _____

Site of exposure: ☐ Residential ☐ Work ☐ Recreational Area (park/campsite) ☐ Lake/River/Ocean ☐ Commercial dwelling ☐ Other _____

Health and Medical Information

Date of illness onset (Required Field) (mm/dd/yyyy): _____/_____/_____

Signs/symptoms (Check all that apply)

☐ Weakness ☐ Headache ☐ Nausea ☐ Chest pain
☐ Dizziness ☐ Drowzines ☐ Vomiting ☐ Shortness of breath
☐ Fatigue ☐ Confusion ☐ Stomach pain ☐ Wheezing
☐ Numbness ☐ Palpitation ☐ Agitation ☐ Loss of consciousness
☐ Other _____

Date of last follow up (mm/dd/yyyy): _____/_____/_____

Resources Used? ☐ 911 Call ☐ ED Only ☐ Treated on Site ☐ Poison Information Call

Was medical care received? ☐ Yes ☐ No ☐ Unknown

If yes, what type? _____

Name of physician: _____ Telephone #: _____

Was injured person hospitalized? ☐ Yes ☐ No ☐ Unknown

If yes, name of medical facility and address: _____

Date of admission (mm/dd/yyyy): _____/_____/_____/ Diagnosis (if available): _____

Type of treatment: _____

Medical outcome: ☐ Survived ☐ Died ☐ Unknown

Date of discharge/death (mm/dd/yyyy): _____/_____/_____

Risk Factor Information

Are there any preexisting conditions? ☐ Yes ☐ No ☐ Unknown

If yes, type of preexisting condition: ☐ COPD ☐ Ischemic heart disease ☐ Other _____

Pregnancy (if applicable)? ☐ Yes ☐ No ☐ Unknown

Smoking status? ☐ Smoker ☐ Non-smoker ☐ Unknown

If smoker _____ (#) cigarettes/ day

Environmental Measurements

Were environmental measurements taken? ☐ Yes ☐ No

If yes, CO level: _____ (ppm), Name and Model of Measuring Device: _____

Test/Laboratory Information

Were laboratory tests performed? ☐ Yes ☐ No ☐ Unknown

If yes, name & location of reporting laboratory: _____

Date and time of test (mm/dd/yyyy): _____/_____/_____ Time _____

Test results: ☐ Elevated COHb level ☐ Normal COHb level ☐ Unknown

Test value: _____

Case Classification

☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case

Investigator's name: _____ Phone: (_____) _____

(Please print)

Please submit form to the Office of Environmental Public Health Medicine, Division of Environmental Health, Department of Health, Bald Cypress Way, Bin A08, Tallahassee, Florida 32399-1712 or FAX 850-922-8472. For questions call 850-245-4299.