



Carbon Monoxide Poisoning Enhanced Case Report Form

Patient Profile Information (Profile Details Screen)

SSN: \_\_\_\_\_ Address: \_\_\_\_\_
Last Name\*: \_\_\_\_\_ City: \_\_\_\_\_
First Name: \_\_\_\_\_ ZIP\*: \_\_\_\_\_
Gender\*: O Male O Female O Unknown County\*: \_\_\_\_\_
Date of Birth\*: \_\_\_\_\_ Home Phone: \_\_\_\_\_
Race\*: O American Indian/Alaskan Native Other Phone: \_\_\_\_\_
O Asian/Pacific Islander Emergency Contact: \_\_\_\_\_
O Black Email: \_\_\_\_\_
O Unknown
O White
O Other
Ethnicity\*: O Hispanic O Non-Hispanic O Unknown

Case Information (Basic Data Screen)

Dx Status\*: O Confirmed Date Onset: \_\_\_\_\_ Date Diagnosis: \_\_\_\_\_
O Probable Lab Report Date: \_\_\_\_\_ CHD Notified Date\*: \_\_\_\_\_
O Suspect
O Unknown
O Not a case

Additional Case Information (Basic Data Screen)

State or Country Where Exposed\*: \_\_\_\_\_
Investigator: \_\_\_\_\_ CHD Reference #: \_\_\_\_\_
Outbreak\*: O Outbreak Associated Outbreak ID: \_\_\_\_\_
O Sporadic
O Unknown
Case Classification\*: O Primary
O Secondary
O Unknown
First Notified via ELR\*: O Yes
O No, how first notified\*: \_\_\_\_\_
Reporter Name: \_\_\_\_\_

Clinical Information (Basic Data Screen)

Yes No Unknown
Investigated\*: O O O Date Investigated: \_\_\_\_\_
Interviewed: O O O Date Interviewed: \_\_\_\_\_
Symptomatic at interview: O O O
Pregnant: O O O Yes No Unknown
Died: O O O Died From This Illness: O O O
ED Visit: O O O
Inpatient Hospitalization\*: O O O Hospitalized for This Illness: O O O
Insurance: O O O Medicaid: O O O
Insurance Notes: \_\_\_\_\_

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## Sensitive Employment/Attendance Information (Basic Data Screen)

- Day Care\*:  Attendee  
 Staff  
 No  
 Unknown

- Occupation\*:  Food Handler  
 Health Care Worker  
 No or Non-Sensitive Occupation  
 Unknown

Company: \_\_\_\_\_

Address: \_\_\_\_\_

ZIP: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_

State: \_\_\_\_\_

Fax: \_\_\_\_\_

Date Last Attended: \_\_\_\_\_

## Provider Information (Basic Data Screen)

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

State\*: \_\_\_\_\_ ZIP: \_\_\_\_\_

Fax: \_\_\_\_\_

## Interview Attempts (Symptoms Screen)

Attempt 1 date/time: \_\_\_\_\_ Attempt 2 date/time: \_\_\_\_\_ Attempt 3 date/time: \_\_\_\_\_

## Surveillance System Identifiers (Event Survey Screen)

1. Florida Poisoning Information Control Network (FPICN) ID (CaseNumber): \_\_\_\_\_
2. ESSENCE-FL ID (EssenceID): \_\_\_\_\_
3. ESSENCE-FL medical record number (MedRecNo): \_\_\_\_\_
4. If part of a cluster of cases, specify cluster: \_\_\_\_\_

## Exposure/Incident Information (Event Survey Screen)

5. Date of incident: \_\_\_\_\_
6. Time of incident: \_\_\_\_\_
7. Brief description of incident: \_\_\_\_\_
8. Total number of people exposed: \_\_\_\_\_

If >1 person was exposed to carbon monoxide during an incident, how were those people related (e.g., household members, neighbors, co-workers, etc.)? \_\_\_\_\_

9. Poisoning intent:  Intentional  
 Unintentional  
 Unknown
10. Type of exposure:  Generator  Fuel-burning appliances (fixed stove/boiler/furnace)  
 Automobile/RV  Portable-fuel burning grill/stove  
 Boat  Unknown  
 Fire  Other: \_\_\_\_\_  
 Kerosene/gas space heater  Multiple exposures: \_\_\_\_\_  
 Gas-powered tools (including mower)
11. Site of exposure:  Residential  Unknown  
 Recreational area (park/campsite)  Other: \_\_\_\_\_  
 Lake/river/ocean  Multiple sites: \_\_\_\_\_  
 Commercial dwelling

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## Heath and Medical (Event Survey Screen)

12. Case symptoms

	Onset Date/Time		Onset Date/Time
<input type="checkbox"/> Abdominal Pain	_____	<input type="checkbox"/> Fatigue	_____
<input type="checkbox"/> Agitation	_____	<input type="checkbox"/> Headache	_____
<input type="checkbox"/> Chest Pain	_____	<input type="checkbox"/> Loss of Consciousness	_____
<input type="checkbox"/> Confusion	_____	<input type="checkbox"/> Nausea	_____
<input type="checkbox"/> Dizziness	_____	<input type="checkbox"/> Numbness	_____
<input type="checkbox"/> Drowsiness	_____	<input type="checkbox"/> Palpitation	_____
		<input type="checkbox"/> Shortness of Breath	_____
		<input type="checkbox"/> Vomiting	_____
		<input type="checkbox"/> Weakness	_____
		<input type="checkbox"/> Wheezing	_____
		<input type="checkbox"/> Other: _____	_____

13. What did the patient do after realizing there was a problem?

	Yes	No	Unknown	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Called 911
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Called fire department
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Called police department
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Called poison control
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Called friends or neighbors
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Called family members
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Left the house
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Turned off source of exposure
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Opened windows or doors
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Went to doctor's office or emergency room
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Treated on site
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other: _____

14. How did patient get to medical care?

Self-transport  
 EMS transport  
 Other: \_\_\_\_\_

If EMS transport, how long did it take them to respond?

\_\_\_\_\_ Hours \_\_\_\_\_ Minutes

15. Did the patient receive hyperbaric oxygen treatment?

Yes  
 No  
 Unknown

16. Was carboxyhemoglobin (COHb) level tested?

Yes, level (in %): \_\_\_\_\_  
 No  
 Unknown

If yes, COHB level measurement device:

CO-oximeter (hospital)  
 Pulse CO-oximetry (EMS)  
 Unknown  
 Other: \_\_\_\_\_

17. Did the patient have any preexisting conditions?

Yes  
 No  
 Unknown

If yes, type of preexisting condition:

COPD  
 Ischemic heart disease  
 Unknown  
 Other: \_\_\_\_\_  
 Multiple conditions: \_\_\_\_\_

18. Smoking status:

Smoker, number of cigarettes per day: \_\_\_\_\_  
 Non-smoker  
 Unknown

# Carbon Monoxide Poisoning Enhanced Case Report Form

## Environmental Measures (Event Survey Screen)

19. Were environmental measurements taken?  Yes  
 No  
 Unknown

If yes, carbon monoxide level (ppm): \_\_\_\_\_

If yes, name and model of measuring device: \_\_\_\_\_

## Carbon Monoxide Detector (Event Survey Screen) - Complete only for residential exposures

20. Was there a carbon monoxide detector in the home?  Yes  
 No  
 Unknown

If yes, did the patient ever hear the carbon monoxide detector alarm go off?  Yes  
 No  
 Unknown

If yes, was action taken when the patient heard it go off (e.g., leave the house, open windows or doors, turn off the generator)?  Yes  
 No  
 Unknown

If yes, specify location of detector(s) in the home:  Living room  Bedroom  
 Kitchen  Hall  
 Bathroom  Garage  
 Other: \_\_\_\_\_

If yes, how is the carbon monoxide detector operated?  Electrical wall power  
 Battery  
 Both  
 Unknown

If operated by electrical wall power, does the carbon monoxide detector have a battery for back-up?  Yes  
 No  
 Unknown

If the carbon monoxide detector uses a battery, when was the last time the battery was checked to make sure it was working?  Within last 6 months  
 Between 6 months and 1 year  
 Over 1 year ago  
 Have not checked  
 Unknown

## Generator-Related Exposures (Event Survey Screen) – Complete only if exposure was generator

21. For what type of building was the generator being used?  Motor home or RV  
 Mobile home or trailer  
 Single-family house  
 Multiple unit house (duplex, triplex, etc.)  
 Apartment or condominium  
 Unknown  
 Other: \_\_\_\_\_

22. Why was the generator being used?  Residence/location where staying lost power due to storm  
 Residence/location where staying lost power due to another reason  
 Other: \_\_\_\_\_

If used due to lost power, how long was the power out? \_\_\_\_\_ Days \_\_\_\_\_ Hours

# Carbon Monoxide Poisoning Enhanced Case Report Form

## Generator-Related Exposures (Event Survey Screen) - Complete only if exposure was generator

How did the patient get news and information (e.g., community news, information about power outages and restoration) while the power was out?	Yes <input type="radio"/>	No <input type="radio"/>	Unknown <input type="radio"/>	Newspaper Internet Social media: _____ Radio Television From friends, family, or neighbors Professionals (e.g., relief workers, health care providers) Power company, specify methods below
	Yes <input type="radio"/>	No <input type="radio"/>	Unknown <input type="radio"/>	Visited power company website Called power company Received text messages Received emails Social media: _____

23. Please list all people where were present when the patient was exposed and whether they were symptomatic and sought health care. Symptoms include headaches, fatigue or weakness, dizziness or lightheadedness, confusion, loss of consciousness, nausea, vomiting, chest pain, or shortness of breath.

Name	Zip	Phone	Age	Gender	Symptomatic	Sought medical care
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>

If additional space is needed, please use last section "Additional People Present at Time of Exposure".

24. How did the patient first realize there was a problem?

CO alarm sounded  
 Woke up (alarm clock)  
 Someone felt sick  
 Dog barking  
 Friend or neighbor told patient  
 Unknown  
 Other: \_\_\_\_\_

25. How long was the generator running before symptoms were noticed in any person in the household?

\_\_\_\_\_ Days    \_\_\_\_\_ Hours    \_\_\_\_\_ Minutes

26. How many generators were being used? \_\_\_\_\_

27. Where was the generator(s) located:

Inside the home, specify rooms: \_\_\_\_\_

If yes, were window(s) open in the room where the generator was running?	Yes	No	Unknown
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, were door(s) open in the room where the generator was running?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, was there other ventilation? Specify: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Inside the garage

If yes, was the garage attached to the home?	Yes	No	Unknown
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, was the garage door open while the generator was running?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

On an attached open porch or deck

In a covered porch, deck, or carport

Other outside area

In another unattached structure

Other: \_\_\_\_\_

# Carbon Monoxide Poisoning Enhanced Case Report Form

## Generator-Related Exposures (Event Survey Screen) - Complete only if exposure was generator

28. If the generator was not inside the home:  
 How far was the generator from nearest window or door of the home (in feet)? \_\_\_\_\_  Unknown  
 How far was the generator from nearest air conditioner or air intake vent (in feet)? \_\_\_\_\_  Unknown

29. Why did the patient choose this location(s)?

	Yes	No	Unknown	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	As far as the extension cord would reach
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Keep it out of rain and wind
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Keep it out of flood water
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concern about noise
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concern about theft
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concern about exhaust
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Too difficult to move farther
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other: _____

30. Did the patient own a generator prior to this incident?  Yes  
 No  
 Unknown

If yes, for how long? \_\_\_\_\_

31. Had the patient ever used a generator prior to this incident?  Yes  
 No  
 Unknown

If yes, how many times was it used in the past 5 years? \_\_\_\_\_

32. Generator brand: \_\_\_\_\_ Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year: \_\_\_\_\_

33. How did the patient get the generator(s)?

	Yes	No	Unknown	
<input type="radio"/> <input type="radio"/> <input type="radio"/> Bought	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	If yes, from where?
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Wal-Mart
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> From family member or relative
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Home Depot
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Lowe's
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other hardware store: _____
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other store: _____
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other location: _____
<input type="radio"/> <input type="radio"/> <input type="radio"/> Rented	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	If yes, from where?
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> From family member or relative
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Home Depot
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Lowe's
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other hardware store: _____
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other store: _____
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other location: _____
<input type="radio"/> <input type="radio"/> <input type="radio"/> Borrowed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	If yes, from whom?
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Family member or relative
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Friend or neighbor
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other: _____
<input type="radio"/> <input type="radio"/> <input type="radio"/> Given	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	If yes, by whom?
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> FEMA
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Store: _____
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Other: _____
<input type="radio"/> <input type="radio"/> <input type="radio"/> Other:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

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## Generator-Related Exposures (Event Survey Screen) - Complete only if exposure was generator

34. If the generator was purchased or rented:

Did the patient buy a carbon monoxide detector at the same time?  Yes  
 No  
 Unknown

If no, was the patient advised to buy one?  Yes  
 No  
 Unknown

If a carbon monoxide detector had been provided with the generator would the patient have likely installed it?  Yes  
 No  
 Unknown

35. Was the patient ever told how to safely operate the generator?  Yes  
 No  
 Unknown

If yes, was the patient told before obtaining generator, at the time the generator was obtained, or after?  Before obtaining  
 At the time obtained  
 After obtaining  
 Unknown

If yes, by whom:

Yes	No	Unknown	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Friend or neighbor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Family member or relative
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Salesman or store employee
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Read owners' manual
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	FEMA representative
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other: _____

36. Did the generator have any visible warnings about carbon monoxide?  Yes  
 No  
 Unknown

If yes, was it in a language the patient could read?  Yes  
 No  
 Unknown

37. Did the patient read or hear any warning about carbon monoxide poisoning at any time before or after the storm?  Yes  
 No  
 Unknown

If yes, did the patient read or hear the warning before the exposure occurred?  Yes  
 No  
 Unknown

If yes, where did the patient read or hear about the warning?

Yes	No	Unknown	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Newspapers/magazines
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pamphlet/fact sheet
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Facebook
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Twitter
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	YouTube
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fire department
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Radio
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Television
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Friends, family, or neighbors
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Salesman or store employee
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Law enforcement
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Utility workers
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other: _____

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## Generator-Related Exposures (Event Survey Screen) - Complete only if exposure was generator

38. Read the sentences below to the interviewee and ask them agree, disagree, or say they do not know:

Agree    Disagree    Don't Know

- |                       |                       |                       |                                                                                                                |
|-----------------------|-----------------------|-----------------------|----------------------------------------------------------------------------------------------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | a. Portable generators can be safely operated indoors with closed windows and doors.                           |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | b. Portable generators can be safely operated indoors with windows open.                                       |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | c. Portable generators can be safely operated indoors with open windows and doors and a running exhaust fan.   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | d. Carbon monoxide has a smell.                                                                                |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | e. Carbon monoxide has a taste.                                                                                |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | f. Carbon monoxide can be seen.                                                                                |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | g. Carbon monoxide can burn your eyes.                                                                         |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | h. Carbon monoxide poisoning can occur quickly within hours of generator operation.                            |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | i. Carbon monoxide poisoning can occur after a generator has been in operation for several days.               |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | j. Portable generators can be safely operated on an attached porch, deck, or carport or in an attached garage. |

## Miscellaneous (Event Survey Screen)

39. Primary language spoken in the patient's home:
- English
  - Spanish
  - Haitian Creole
  - Other: \_\_\_\_\_
  - Unknown
40. Total number of people in the patient's household: \_\_\_\_\_
41. Patient's total household income in the past year from all sources:
- <\$15,000
  - \$15,000 - \$19,999
  - \$20,000 - \$24,999
  - \$25,000 - \$34,999
  - \$35,000 - \$49,999
  - \$50,000 - \$74,999
  - \$75,000+
  - Unknown
  - Refused

## Additional People Present at Time of Exposure (If Needed)

Name	Zip	Phone	Age	Gender	Symptomatic	Sought medical care
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>	<input type="checkbox"/>