



Case #: _____

Pesticide Incident Monitoring/Reporting Form

Fax to:
DOH/Bureau of Epidemiology
Attn: Pesticide Exposure Surveillance Program
Fax number: (850) 414-6894

Call:
Telephone number: (850) 245-4277
Pesticide Poisoning Hotline: **1-800-606-5810**

Reporting Person/Agency Information

Report date: _____ Report time: _____ Report source: _____
Person/Organization reporting: _____ Title: _____
Street Address: _____ Telephone #: _____
Person/Organization who received report: _____ Title: _____

Exposed Person Demographic Information

Name: _____ Date of Birth: ____/____/____
 First M.I. Last
Street address: _____
City: _____ County: _____ Zip: _____
Telephone #: Home: _____ Work: _____ Other: _____
Sex: Male **Race/Ethnicity:** White Hispanic Asian
 Female Black Native American Other _____

Exposure/Incident Information

Date & time of incident: _____ Type/Name of pesticide: _____
Brief description of incident: _____
Type of exposure: _____ Site of exposure: _____
Activity at time of exposure: _____
Was injury work related? Yes No Possible Unknown
If yes, company name: _____ Occupation/Type of work: _____
Street address: _____ City: _____ Zip: _____
Were other persons exposed? Yes (Attach list) No Unknown

Health and Medical Information

Date of illness onset (Required Field): _____ Date of last follow up: _____
Signs/symptoms (Check all that apply)
 Abdominal Pain Eye Irritation Dizziness Rash Restlessness
 Diarrhea Lacrimation Blurred Vision Burns Fatigue
 Constipation Conjunctivitis Chest Pains Redness Headache
 Nausea Dyspnea Wheezing Pruritis Confusion
 Vomiting Salivation UR Pain Bullae Weakness
 Altered Taste Sweating Brachycardia Edema Convulsion
 Others _____

Case #: _____ Case File Name: _____ Exposure Date: _____

Health and Medical Information

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: _____ Diagnosis (if available): _____
Are there any preexisting conditions? Yes No Unknown
If yes, type of preexisting condition: _____
Type of treatment: _____ Date of discharge/death: _____

Test/Laboratory Information

Name & Location of reporting laboratory: _____
Type of test: Cholinesterase Pesticide Metabolite Other _____
Test results: Positive Negative Unknown
Date of Test: _____ Substance(s) detected: _____

Exposure and Health Effect Workup (To be filled out ONLY by DOH Investigator)

Is the illness/injury related to pesticide exposure? Yes No Unknown

If yes, why? (Check all that apply):

- Signs and symptoms are consistent with the pesticide poisoning
- Confirmatory laboratory/environmental evidence (Attach conclusive test results)
- Clinical diagnosis consistent with environmental/laboratory findings (Attach medical report)
- Existence of temporal relationship between exposure and illness

Case classification (Evidence of health effects and linkage to pesticide toxicity):

- Definite Probable Possible Suspicious
- Unlikely Insufficient Not a Case Unknown

Length of hospitalization: _____ Length of time taken from work/activities: _____

Severity Classification (Illness/injury duration and health outcome):

- Fatal High Medium Low

Investigator's name: _____ Telephone #: _____