ACC No: 3917 VF EOPE .A28

Acute occupational pesticide poisoning surveillance case report [form]

TDH

TDH Case # _____
Date Report Received at TDH ____/____/____
MM DD YY
Source of Initial Report _____
(TDH Use Only)

ACUTE OCCUPATIONAL PESTICIDE POISONING SURVEILLANCE CASE REPORT
TEXAS DEPARTMENT OF HEALTH, BUREAU OF EPIDEMIOLOGY

DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

STREET ADDRESS	CITY	ZIP CODE	COUNTY	COUNTY CODE (TDH use only)

TELEPHONE NUMBER	DATE OF BIRTH	AGE	SEX	SOCIAL SECURITY NUMBER
( )	____/____/____ MM DD YY		___ 1 MALE ___ 2 FEMALE	_____-_____-_____

RACE/ETHNICITY
___ 1 WHITE, NOT HISPANIC ___ 2 HISPANIC ___ 3 BLACK
___ 4 AMERICAN INDIAN/ALASKAN NATIVE ___ 5 ASIAN/PACIFIC ISLANDER

ENGLISH SPEAKING
___ 1 YES
___ 2 NO

NAME OF EMPLOYER (COMPANY OR BUSINESS) AT TIME OF PESTICIDE EXPOSURE

STREET ADDRESS	CITY	ZIP CODE	COUNTY	COUNTY CODE (TDH use only)

TYPE OF BUSINESS — INDUSTRY CODE (TDH use only)

JOB (TYPE) AT TIME OF EXPOSURE TO PESTICIDE — OCCUPATION CODE (TDH use only)

ARE THERE NONOCCUPATIONAL ACTIVITIES THAT MAY HAVE RESULTED IN PESTICIDE EXPOSURE? ___ 1 YES ___ 2 NO
IF YES, PLEASE DESCRIBE:

EXPOSURE INFORMATION

LOCATION OF PESTICIDE EXPOSURE (If rural, directions from the nearest town)

STREET ADDRESS	CITY	ZIPCODE	COUNTY	COUNTY CODE (TDH use only)

DATE OF EXPOSURE	TIME OF EXPOSURE	CIRCUMSTANCE OF EXPOSURE
____/____/____ MM DD YY	___ a.m. ___ p.m.	___ 1 Agricultural Application ___ aerial ___ ground ___ mining/loading ___ 2 Commercial/Residential Application ___ 3 Work in Recently Treated Field/Other Work Site ___ 4 Pesticide Manufacturer/ Formulation ___ 5 Other _____

TYPE OF PESTICIDE (Check all that apply)	Formulation Type	Route of Exposure
___ 1 Insecticide ___ 5 Disinfectant ___ 2 Herbicide ___ 6 Other (specify) _____ ___ 3 Fungicide ___ 4 Rodenticide ___ 7 Unknown	___ 1 aerosol/spray ___ 2 dust/granular ___ 3 bait ___ 4 liquid	___ 1 Dermal ___ 5 Unknown ___ 2 Ingestion ___ 3 Inhalation ___ 4 Other _____

PRODUCT NAME(S)	EPA REGISTRATION NO (from label)	ACTIVE INGREDIENTS (from label)	INGREDIENT CODES (TDH use only)

REPORTING (OR ATTENDING) PHYSICIAN | ADDRESS | TELEPHONE

( )

DIAGNOSIS BASED UPON (Check all that apply):

____ 1 Known Exposure
____ 2 Symptomatology
____ 3 Diagnostic laboratory tests
____ 4 Pesticide Residue/Metabolites
____ 5 Other _____

SIGNS/SYMPTOMS/SEQUELAE (Check all that apply):

Nervous/Sensory
____ 1 Yes
____ 2 No

____ 101 Ataxia
____ 103 Blurred/dark vision
____ 105 Coma
____ 107 Confusion
____ 109 Convulsions
____ 111 Dizziness
____ 113 Eye Irritation
____ 115 Fainting/Unconscious
____ 117 Headache
____ 119 Hyperactivity
____ 121 Numbness (location)
_____
____ 123 Paralysis
____ 125 Pinpoint pupils
____ 127 Sweating profusely
____ 129 Tremors
____ 131 Weakness
____ 133 Other _____
_____

Cardiovascular
____ 1 Yes
____ 2 No

____ 201 Cyanosis
____ 203 Rapid/Slow heartbeat
Specify _____
_____
____ 205 Hypertension/Hypotension
Specify _____
____ 207 Other _____
_____

Gastrointestinal/Liver
____ 1 Yes
____ 2 No

____ 301 Abdominal Pain/Cramps
____ 303 Diarrhea
____ 305 Jaundice
____ 307 Nausea/Vomiting
____ 309 Salivation
____ 311 Hepatomegally/Enlarged/
Tender Liver
____ 313 Other
_____

Respiratory
____ 1 Yes
____ 2 No

____ 401 Chest tightness
____ 403 Difficulty breathing
____ 405 Pulmonary edema
____ 407 Shortness of Breath
____ 409 Nose/Throat irritation
____ 411 Wheezing
____ 413 Chest pain
____ 415 Coughing
____ 417 Other _____
_____

Renal/Urinary
____ 1 Yes
____ 2 No

____ 501 Incontinence
____ 503 Renal failure
____ 505 Hematuria/proteinuria
____ 507 Other _____
_____

Other
____ 1 Yes
____ 2 No

____ 601 Fatigue
____ 603 Malaise
____ 605 Skin irritation/rash
____ 607 Hematopoietic
____ 609 Musculoskeletal
____ 611 Hyperthermia/Fever
____ 613 Other _____
_____

Date of Death, if deceased
_____/_____/_____
MM DD YY

Type of Medical Care:

____ 1 Physician office visit
____ 2 Emergency room visit
____ 3 Hospital admission _____
No of days

Residual Signs or Symptoms:
_____
_____

at (number days post exposure)
_____

LABORATORY TESTS DONE ____ 1 Yes ____ 2 No (If yes, complete below. Attach laboratory reports, if available.)

NAME OF LABORATORY(IES) | ADDRESS | TELEPHONE

( )

PESTICIDE RESIDUE/METABOLITES IN BODY FLUIDS/TISSUE, ETC?

____ 1 yes (complete below) ____ 2 No ____ 3 Not obtained

1 ____ Unknown substances only found
2 ____ Low levels found, consistent with suspected pesticide(s)
3 ____ Significant levels found, consistent with suspected pesticide(s)

DATE OF SAMPLE
_____/_____/_____
MM DD YY

CHOLINESTERASE LEVELS OBTAINED
(Document laboratory methods, dates, and levels obtained.)

__1 Yes ____ 2 No

If yes: ____ 1 All normal ____ 2 Abnormal (complete below)
____ 1 only rbc cholinesterase low
____ 2 only plasma cholinesterase low
____ 3 both plasma and rbc cholinesterase low

Date	Laboratory Method	Rbc/ Plasma	Result
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____
___/___/___	_____	_____	_____

____ 1 Elevated SGOT ____ 3 Elevated SGPT ____ 5 Elevated creatinine ____ 7 Other _____
____ 2 Elevated BUN ____ 4 Elevated LDH ____ 6 Elevated Alkaline _____

OTHER RELEVANT (NORMAL OR ABNORMAL) LABORATORY/HISTOLOGIC/AUTOPSY FINDINGS

_____

_____

_____

FORM COMPLETED BY

NAME: _____ DATE:

TITLE: _____ ___/___/___
MM DD YY

AGENCY: _____

TDH USE ONLY

____ CASE CONTACTED ____ INDUSTRIAL ASSESSMENT CONDUCTED ____ EMPLOYER CONTACTED

____ REFERRED TO ANOTHER AGENCY _____
(specify where)

____ OTHER CASES DISCOVERED ____ ENTERED INTO TDH BUREAU OF EPIDEMIOLOGY REGISTER

RETURN COMPLETED FORM TO:

ATTENTION: TERESA M. WILLIS
EPIDEMIOLOGY DIVISION
TEXAS DEPARTMENT OF HEALTH
1100 WEST 49TH STREET
AUSTIN, TEXAS 78756