

ARIZONA DEPARTMENT OF HEALTH SERVICES

Pesticide Poisoning Surveillance and Reporting Program

150 N. 18th Avenue, Suite 430

Phoenix, AZ 85007

PESTICIDE POISONING SURVEILLANCE REPORT (602-364-3118/800-367-6412)

*PATIENT'S NAME		*PHONE	*DATE OF BIRTH																														
*STREET ADDRESS		*CITY	*ZIP CODE																														
*SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	*RACE/ETHNICITY <input type="checkbox"/> WHITE, NON HISPANIC ORIGIN <input type="checkbox"/> HISPANIC <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK, NON HISPANIC ORIGIN <input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> OTHER _____																																
*DATE ONSET	*DATE DIAGNOSIS	*OCCUPATION																															
PHYSICIAN'S NAME (OR PERSON MAKING REPORT IF OTHER THAN PHYSICIAN)			PHONE																														
NAME AND ADDRESS OF FACILITY		CITY	ZIP CODE																														
HEALTH CARE FACILITY: <input type="checkbox"/> DR. OFFICE/CLINIC <input type="checkbox"/> URGENT CARE (ER) <input type="checkbox"/> HOSPITALIZATION																																	
NAME OF PESTICIDE(S) (IF KNOWN)																																	
SYMPTOMS OF POISONING (PLEASE CHECK ALL THAT APPLY) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> ABDOMINAL CRAMPS</td> <td><input type="checkbox"/> TACHYCARDIA</td> <td><input type="checkbox"/> BLURRED VISION</td> <td><input type="checkbox"/> DISORIENTATION</td> <td><input type="checkbox"/> RESTLESSNESS</td> </tr> <tr> <td><input type="checkbox"/> EYE IRRITATION</td> <td><input type="checkbox"/> CHEST PAIN</td> <td><input type="checkbox"/> INCONTINENCE</td> <td><input type="checkbox"/> IN-COORDINATION</td> <td><input type="checkbox"/> TWITCHING</td> </tr> <tr> <td><input type="checkbox"/> DIZZINESS</td> <td><input type="checkbox"/> SALIVATION</td> <td><input type="checkbox"/> CONVULSION</td> <td><input type="checkbox"/> APPREHENSION</td> <td><input type="checkbox"/> SWEATING</td> </tr> <tr> <td><input type="checkbox"/> ANOREXIA</td> <td><input type="checkbox"/> HEADACHE</td> <td><input type="checkbox"/> LACRIMATION</td> <td><input type="checkbox"/> BRADYCARDIA</td> <td><input type="checkbox"/> MIOSIS</td> </tr> <tr> <td><input type="checkbox"/> CYANOSIS</td> <td><input type="checkbox"/> DIARRHEA</td> <td><input type="checkbox"/> PARALYSIS</td> <td><input type="checkbox"/> RESPIRATORY</td> <td><input type="checkbox"/> OTHER</td> </tr> <tr> <td><input type="checkbox"/> FATIGUE</td> <td><input type="checkbox"/> NAUSEA</td> <td><input type="checkbox"/> VOMITING</td> <td><input type="checkbox"/> MUSCULAR FASCICULATION</td> <td></td> </tr> </table>				<input type="checkbox"/> ABDOMINAL CRAMPS	<input type="checkbox"/> TACHYCARDIA	<input type="checkbox"/> BLURRED VISION	<input type="checkbox"/> DISORIENTATION	<input type="checkbox"/> RESTLESSNESS	<input type="checkbox"/> EYE IRRITATION	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> INCONTINENCE	<input type="checkbox"/> IN-COORDINATION	<input type="checkbox"/> TWITCHING	<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> SALIVATION	<input type="checkbox"/> CONVULSION	<input type="checkbox"/> APPREHENSION	<input type="checkbox"/> SWEATING	<input type="checkbox"/> ANOREXIA	<input type="checkbox"/> HEADACHE	<input type="checkbox"/> LACRIMATION	<input type="checkbox"/> BRADYCARDIA	<input type="checkbox"/> MIOSIS	<input type="checkbox"/> CYANOSIS	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> PARALYSIS	<input type="checkbox"/> RESPIRATORY	<input type="checkbox"/> OTHER	<input type="checkbox"/> FATIGUE	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> VOMITING	<input type="checkbox"/> MUSCULAR FASCICULATION	
<input type="checkbox"/> ABDOMINAL CRAMPS	<input type="checkbox"/> TACHYCARDIA	<input type="checkbox"/> BLURRED VISION	<input type="checkbox"/> DISORIENTATION	<input type="checkbox"/> RESTLESSNESS																													
<input type="checkbox"/> EYE IRRITATION	<input type="checkbox"/> CHEST PAIN	<input type="checkbox"/> INCONTINENCE	<input type="checkbox"/> IN-COORDINATION	<input type="checkbox"/> TWITCHING																													
<input type="checkbox"/> DIZZINESS	<input type="checkbox"/> SALIVATION	<input type="checkbox"/> CONVULSION	<input type="checkbox"/> APPREHENSION	<input type="checkbox"/> SWEATING																													
<input type="checkbox"/> ANOREXIA	<input type="checkbox"/> HEADACHE	<input type="checkbox"/> LACRIMATION	<input type="checkbox"/> BRADYCARDIA	<input type="checkbox"/> MIOSIS																													
<input type="checkbox"/> CYANOSIS	<input type="checkbox"/> DIARRHEA	<input type="checkbox"/> PARALYSIS	<input type="checkbox"/> RESPIRATORY	<input type="checkbox"/> OTHER																													
<input type="checkbox"/> FATIGUE	<input type="checkbox"/> NAUSEA	<input type="checkbox"/> VOMITING	<input type="checkbox"/> MUSCULAR FASCICULATION																														
LABORATORY RESULTS:	WERE TESTS PERFORMED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DATE(S) ____/____/____																														
CHOLINESTERASE:	<input type="checkbox"/> PLASMA	LEVEL IN UNITS: _____	NORMAL RANGE USED: _____																														
	<input type="checkbox"/> RED BLOOD CELL	LEVEL IN UNITS: _____	NORMAL RANGE USED: _____																														
LEVELS ARE:	<input type="checkbox"/> ELEVATED	<input type="checkbox"/> NORMAL	<input type="checkbox"/> DEPRESSED																														
WHAT TREATMENT ADMINISTERED:	<input type="checkbox"/> ATROPINE	<input type="checkbox"/> PRALDOXIME	<input type="checkbox"/> OTHER _____																														
DATE(S) ____/____/____	URINE METABOLITES:	LEVEL IN UNITS: _____	URINE PH: _____																														
DATE(S) ____/____/____	ADIPOSE TISSUE TESTED:	<input type="checkbox"/> YES <input type="checkbox"/> NO	LEVEL IN UNITS: _____																														
DATE(S) ____/____/____	OTHER TEST PERFORMED:	TYPE: _____	RESULTS: _____																														
*REASON FOR BELIEVING THE ILLNESS IS CAUSED BY OR RELATED TO DOCUMENTED EXPOSURE TO A PESTICIDE: (CHECK ALL THAT APPLY) <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> SYMPTOMS GENERALLY APPROPRIATE FOR PESTICIDE RELATED ILLNESS</td> <td><input type="checkbox"/> SYMPTOMS APPROPRIATE FOR IMPLICATED PESTICIDE</td> </tr> <tr> <td><input type="checkbox"/> EVIDENCE OF TEMPORAL RELATIONSHIP BETWEEN EXPOSURE AND ILLNESS</td> <td><input type="checkbox"/> SUPPORTING LABORATORY EVIDENCE</td> </tr> <tr> <td><input type="checkbox"/> RESULTS OF TREATMENT CONSISTENT WITH PESTICIDE ILLNESS</td> <td><input type="checkbox"/> SUPPORTING PATIENT HISTORY</td> </tr> <tr> <td></td> <td><input type="checkbox"/> OTHER _____</td> </tr> </table>				<input type="checkbox"/> SYMPTOMS GENERALLY APPROPRIATE FOR PESTICIDE RELATED ILLNESS	<input type="checkbox"/> SYMPTOMS APPROPRIATE FOR IMPLICATED PESTICIDE	<input type="checkbox"/> EVIDENCE OF TEMPORAL RELATIONSHIP BETWEEN EXPOSURE AND ILLNESS	<input type="checkbox"/> SUPPORTING LABORATORY EVIDENCE	<input type="checkbox"/> RESULTS OF TREATMENT CONSISTENT WITH PESTICIDE ILLNESS	<input type="checkbox"/> SUPPORTING PATIENT HISTORY		<input type="checkbox"/> OTHER _____																						
<input type="checkbox"/> SYMPTOMS GENERALLY APPROPRIATE FOR PESTICIDE RELATED ILLNESS	<input type="checkbox"/> SYMPTOMS APPROPRIATE FOR IMPLICATED PESTICIDE																																
<input type="checkbox"/> EVIDENCE OF TEMPORAL RELATIONSHIP BETWEEN EXPOSURE AND ILLNESS	<input type="checkbox"/> SUPPORTING LABORATORY EVIDENCE																																
<input type="checkbox"/> RESULTS OF TREATMENT CONSISTENT WITH PESTICIDE ILLNESS	<input type="checkbox"/> SUPPORTING PATIENT HISTORY																																
	<input type="checkbox"/> OTHER _____																																
DIAGNOSIS: <input type="checkbox"/> DEFINITE <input type="checkbox"/> PROBABLE <input type="checkbox"/> POSSIBLE <input type="checkbox"/> MULTIPLE CHEMICAL SENSITIVITY (MCS) <input type="checkbox"/> ILLNESS NOT LIKELY TO BE RELATED <input type="checkbox"/> INTENTIONAL																																	

* Information is required by Arizona law - A.R.S. 36-606