CONFIDENTIAL PESTICIDE EXPOSURE REPORTING FORM

Reporting of known or suspected pesticide illness is mandatory

Please send to:	**Office of Environmental Health** **Attn: Environmental Health Capacity** **Program 150 N 18th Avenue, Suite 220** **Phoenix, Arizona 85007** **Phone Number: (602) 364-3118** **Fax Number: (602) 364-3146**	For ADHS use Date received: Staff filing report: Follow-up? ☐ Yes ☐ No

Arizona Administrative Code R-94-202 requires physicians to

- report pesticide-related hospitalizations, death, or cluster cases within **1** day
- report all other suspected or confirmed pesticide-related illness within **5** days

Report can be submitted by phone, mail or fax. If faxed, please call ahead to ensure confidentiality. Please retain copy for your files.

Please provide as much as information as possible. Fields marked with an asterisk* are required & critical for follow-up investigations.

PATIENT INFORMATION

Name*: _____ (*First*) _____ (*Last*) Phone*: _____ (###) – _____ (###) – _____ (####)

Address*: _____ (Street Name)

_____ (City) _____ (County) _____ (State) _____ (Zip Code)

Date of Birth*: ____ (MM) / ____ (DD) / _____ (YYYY) Sex*: ☐ Male ☐ Female Email: _____

Race/Ethnicity*: ☐ White – non-Hispanic Origin ☐ Hispanic ☐ Asian ☐ Black – non-Hispanic Origin ☐ Native American ☐ Other: _____

EXPOSURE INFORMATION

Was the pesticide exposure work related*? ☐ Yes Occupation*: _____ ☐ No ☐ Possible ☐ Unknown

Date of Exposure*: ____ (MM) / ____ (DD) / _____ (YYYY) Time of Exposure*: ____ (HH) / ____ (MM) ☐ A.M. ☐ P.M.

Was the Poison Control Center (1-800-222-1222) notified? ☐ Yes ☐ No

Site of Exposure: _____

Name of the pesticide/substance*: _____

How was the patient exposed?

_____

HEALTH & MEDICAL INFORMATION

Date of Illness Onset*: ____ / ____ / ____ (MM / DD / YYYY) Date of Diagnosis*: ____ / ____ ____ (HH / MM / YYYY)

Signs and Symptoms **(check all that apply)**

EYE/OCULAR

☐ miosis/pinpoint pupils ☐ burns ☐ corneal abrasion ☐ lacrimation/tearing
☐ pain/irritation/inflammation ☐ mydriasis/extreme dilation of the pupil
☐ conjunctivitis ☐ other eye (please specify):

RESPIRATORY

☐ cough ☐ wheezing ☐ respiratory depression ☐ pulmonary edema
☐ asthma attack or exacerbation of asthma due to exposure ☐ dyspnea/ shortness of breath
☐ hyperventilation/tachypnea (rapid shallow breathing) ☐ pleuritic chest pain/pain on deep breathing
☐ cyanosis/ bluish discoloration of skin or mucous membranes
☐ lower respiratory tract irritation (rales, rhonchi, chest discomfort, crackles, chest tightness)
☐ upper respiratory pain/irritation (congestion, sinus pain, sore throat, runny nose, oral or nasal rash or blistering, persistent sneezing, burning tongue, laryngitis, post nasal drip, clogged ears, chest heaviness)
☐ other respiratory (please specify):

GASTROINTESTINAL (GI)

☐ abdominal pain/cramping ☐ anorexia/loss of appetite ☐ constipation ☐ diarrhea
☐ nausea ☐ vomiting ☐ GI bleeding
☐ Other GI (please specify):

RENAL/GENITOURINARY

☐ polyuria (frequent passing urine) ☐ oliguria/anuria (reduced or absent urine production)
☐ hematuria (passing blood in urine) ☐ proteinuria (protein in the urine)
☐ Other renal/genitourinary (please specify):

NERVOUS/SENSORY

☐ coma ☐ confusion ☐ seizure ☐ headache
☐ muscle weakness ☐ muscle rigidity ☐ paralysis ☐ peripheral neuropathy
☐ slurred speech ☐ blurred vision ☐ dizziness ☐ muscle pain
☐ fainting ☐ altered taste ☐ memory loss ☐ diaphoresis/profuse sweat
☐ hypersalivation (including drooling and increased salivation) ☐ fasciculations (localized contraction of muscles)
☐ hyperactivity/anxiety/irritability (including nervousness, anxious affect)
☐ paresthesia (sensation of burning or prickling of skin/tingling/numbness apart from specific injury or rash)
☐ other nervous/sensory (please specify):

CARDIOVASCULAR

☐ bradycardia ☐ cardiac arrest ☐ tachycardia ☐ chest pain
☐ palpitations ☐ abnormal heart rate ☐ low arterial blood pressure ☐ high arterial blood pressure
☐ conduction disturbance (including atrial arrhythmia, atrial fibrillation, sinus arrhythmia, or ventricular arrhythmia)
☐ other cardiovascular (please specify):

OTHER SIGNS/SYMPTOMS

☐ fever ☐ acidosis ☐ alkalosis
☐ fatigue/ Malaise (including tired, generalized weakness, groggy, sleepy, lethargic)
☐ other signs/symptoms (please specify):

TEST, TREATMENT & PROVIDER INFORMATION

Was laboratory test conducted*? ☐ Yes ☐ No
Date of specimen collected*: _____ Type of specimen collected*: _____
Type of test performed*: _____

Result of the test*: _____

Was patient treated*? ☐ Yes ☐ No ☐ Unknown

If Yes, please describe the treatment received*. _____

Name of physician*: _____ Phone number*: _____

On what basis the health care professional or medical director believes the individual has pesticide illness*?

Clinical presentation: ☐ Yes ☐ No

If Yes, please describe: _____

Patient history/exposure: ☐ Yes ☐ No

If Yes, please describe: _____

Description of the type of health care institution or poison control center who determined the individual may have a pesticide illness*.

_____

REPORTING PERSON INFORMATION

Name: _____ _____ Phone: _____ — _____ — _____

First *Last* ### ### ####

Address: _____

Street Name

_____ _____ _____

City State Zip Code

E-mai: _____ Language: _____ Relation to the patient: _____

Thank you for reporting a known or suspected pesticide illness!