

Appendix VI (c)

WNV Malathion Application: Human Exposure and Adverse Effects Incident Report

PATIENT INFORMATION				INCIDENT REPORT COMPLETED BY			
GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown				LAST NAME: _____			
Date of Birth: _____ / _____ / _____ Month Day Year				FIRST NAME: _____			
AGE: _____ <input type="checkbox"/> Child <input type="checkbox"/> Adult <input type="checkbox"/> Unknown				DATE: _____ / _____ / _____ Month Day Year			
LAST NAME: _____				TIME: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM			
FIRST NAME: _____				SITE: _____			
PHONE: (_____) _____				PHONE: (_____) _____			
ADDRESS: _____				ADDRESS: _____			
CITY: _____ POSTAL CODE: _____				CITY: _____ POSTAL CODE: _____			
EXPOSURE							
SITE:	<input type="checkbox"/> Home	<input type="checkbox"/> Other residence	<input type="checkbox"/> Workplace	<input type="checkbox"/> School	<input type="checkbox"/> Public Area	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____
ROUTE:	<input type="checkbox"/> Ingestion	<input type="checkbox"/> Inhalation	<input type="checkbox"/> Eyes	<input type="checkbox"/> Skin	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____	
TYPE:	<input type="checkbox"/> Drift	<input type="checkbox"/> Spray	<input type="checkbox"/> Indoor Air	<input type="checkbox"/> Surface	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other _____	
DATE:	_____ / _____ / _____ Month Day Year		TIME: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM				
ADDRESS OF EXPOSURE: _____							
SIGNS AND SYMPTOMS							
Date of onset of symptoms: _____ / _____ / _____ Month Day Year				Time: _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM			
General	Cardiovascular	Central Nervous System	Eyes	Dermal			
<input type="checkbox"/> Drowsiness <input type="checkbox"/> Fever <input type="checkbox"/> Other _____ <hr/> <b style="background-color: #e0e0e0;">Respiratory <input type="checkbox"/> Cough <input type="checkbox"/> Rhinorrhea <input type="checkbox"/> Bronchial secretion <input type="checkbox"/> Bronchoconstriction <input type="checkbox"/> Wheezing <input type="checkbox"/> Respiratory depression <input type="checkbox"/> Other _____	<u>Heart rate</u> <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <u>Blood pressure</u> <input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Other _____ <hr/> <b style="background-color: #e0e0e0;">Gastrointestinal <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Other _____	<input type="checkbox"/> Headache <input type="checkbox"/> Lethargy <input type="checkbox"/> Confusion <input type="checkbox"/> Poor concentration <input type="checkbox"/> Tremor <input type="checkbox"/> Convulsions <input type="checkbox"/> Other _____ <hr/> <b style="background-color: #e0e0e0;">Skeletal Muscles <input type="checkbox"/> Muscle twitching <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Other _____	<input type="checkbox"/> Miosis (pinpoint pupils) <input type="checkbox"/> Blurred vision <input type="checkbox"/> Other _____ <hr/> <b style="background-color: #e0e0e0;">Exocrine Glands <input type="checkbox"/> Salivation <input type="checkbox"/> Lacrimation (tearing) <input type="checkbox"/> Perspiration <input type="checkbox"/> Other _____ <hr/> <b style="background-color: #e0e0e0;">Bladder <input type="checkbox"/> Increased urination <input type="checkbox"/> Other _____	<input type="checkbox"/> Burning sensation <input type="checkbox"/> Hives / welts <input type="checkbox"/> Irritation / pain <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Redness <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____			

