Appendix VIII
WNV Malathion Application: Human Exposure and Adverse Effects
Incident Report

PATIENT INFORMATION		INCIDENT REPORT COMPLETED BY
GENDER: ☐ Male ☐ Female ☐ Unknown		LAST NAME: ________________
Date of Birth: _______/_______/_______ Month Day Year		FIRST NAME: ________________
AGE: ______ ☐ Child ☐ Adult ☐ Unknown		DATE: ________/_________/__________ Month Day Year
LAST NAME: ________________		TIME: ________ : _________ ☐ AM ☐ PM
FIRST NAME: ________________		SITE: ________________
PHONE: (_________)________________		PHONE: (_________)________________
ADDRESS: ________________		ADDRESS: ________________
CITY: ___________________POSTAL CODE: ___________		CITY: ___________________POSTAL CODE: ___________

EXPOSURE

SITE:	☐ Home	☐ Other residence	☐ Workplace	☐ School	☐ Public Area	☐ Unknown	☐ Other _______
ROUTE:	☐ Ingestion	☐ Inhalation	☐ Eyes	☐ Skin	☐ Unknown	☐ Other_____________________	
TYPE:	☐ Drift	☐ Spray	☐ Indoor Air	☐ Surface	☐ Unknown	☐ Other_____________	
DATE:	________/_________/__________ Month Day Year		TIME: _________ : _________		☐ AM	☐ PM	

ADDRESS OF EXPOSURE: ____

____

SIGNS AND SYMPTOMS

Date of onset of symptoms: ________/_________/__________ Month Day Year

Time: _______: _______ ☐ AM ☐ PM

General	Cardiovascular	Central Nervous System	Eyes	Dermal
☐ Drowsiness	Heart rate	☐ Headache	☐ Miosis (pinpoint pupils)	☐ Burning sensation
☐ Fever	☐ Increased	☐ Lethargy	☐ Blurred vision	☐ Hives / welts
☐ Other	☐ Decreased	☐ Confusion	☐ Other	☐ Irritation / pain
________________	Blood pressure	☐ Poor concentration	________________	☐ Itching
Respiratory	☐ Increased	☐ Tremor	**Exocrine Glands**	☐ Rash
☐ Cough	☐ Decreased	☐ Convulsions	☐ Salivation	☐ Redness
☐ Rhinorrhea	☐ Other	☐ Other	☐ Lacrimation (tearing)	☐ Swelling
☐ Bronchial secretion	________________	________________	☐ Perspiration	☐ Other
☐ Bronchoconstriction	**Gastrointestinal**	**Skeletal Muscles**	☐ Other	________________
☐ Wheezing	☐ Nausea	☐ Muscle twitching	________________	
☐ Respiratory depression	☐ Vomiting	☐ Muscle cramps	**Bladder**	
	☐ Diarrhea	☐ Muscle weakness	☐ Increased urination	

☐ Other ____________	☐ Abdominal cramps ☐ Other___________	☐ Other________________	☐ Other	

Did the patient have any of these conditions at the time of exposure?

☐ Asthma ☐ Multiple Chemical Sensitivity ☐ Pregnant

☐ Underlying Medical Conditions If Yes, describe
____

Are there other exposures that may have caused symptoms (e.g. household cleaning products, other pesticides)?

____

MEDICAL TREATMENT OF CASE

☐ Has patient sought any medical attention?

Name of responsible Medical Doctor: ____

Phone Number: (_______)________________________________

Address: ____

Date first seen: _________/__________/__________ Time: ______:______ ☐ AM ☐ PM
Month Day Year

☐ Hospitalized? If yes, hospital name: ____

☐ Emergency room only?

☐ Physician's office only?

☐ RBC Cholinesterase test ordered? If yes, results ? ____

☐ Pseudocholiesterase test ordered? If yes, results? ____

Malathion Related-Illness: ☐ Definite ☐ Probable ☐ Possible ☐ Unlikely

Treatment: ☐ Artificial Respiration ☐ Atropine ☐ Pralidoxime (2-PAM) ☐ Other

Comments: ____

____

____

PLEASE FAX TO: (______)__________________ **FAX NUMBER**: (____)__________________