PATIENT INFORMATION

Parish	Date report received at Health Department	Date Accidental poisoning occurred

Name	Age	Gender
	YRS *MTHS*	M F

Name of Parent / Guardian (Relationship to Case)	Date of Birth	Hosp Name / Docket Number

Telephone Number	Landmarks

Home Address	Where did poisoning occur? *Circle appropriate site*
	Home Day Care center School Other, _____

CLINICAL DATA

Substance suspected of causing poisoning	Quantity ingested

SYMPTOMS	Y	N	SYMPTOMS	Y	N	SYMPTOMS	Y	N
Headache			Drowsiness			Flushing of skin		
Vomiting			Shortness of breath			Dizziness		
Diarrhoea			Convulsions			Delirium		
Burning sensation in mouth			Loss of consciousness			Weakness		

Was this patient hospitalized? Where?	Outcome of Illness	If patient died, state date of death
Y N Adm. Date: Disch. Date Hospital Name ……	Survived Resolved Died Sequelae present	…… Post Mortem done? Y N DK

Treatment given at Home (i.e. home remedy etc)	Treatment given at Health Care Facility

EXPOSURE HISTORY
Describe the circumstances under which the poisoning incident occurred

LABORATORY DATA		
SPECIMEN	**DATE**	**RESULT**

FINAL CLASSIFICATION

CONFIRMED CASE

DISCARDED CASE

ACTIONS TAKEN / RECOMMENDATIONS

Name/Position of person completing the form:

Signature: Date:

SOCIAL AND ENVIRONMENTAL CONDITIONS
GENERAL STATUS

SAFETY FEATURES IN HOME				
	Y	**N**	**If no to any, give details**	**Y** **N**
Presence of appropriate cupboards			Presence of doors	
Presence of appropriate storage areas for household chemicals			Inaccessible to children	
Presence of appropriate storage areas for pharmaceuticals			Presence of child-proof locks	
Presence of appropriate storage areas for other chemicals				

OTHER RELEVANT INFORMATION (Physical Description of agent implicated)