

Unique Case ID \_\_\_\_\_

Interviewer ID \_\_\_\_\_

**Patient/Victim Information Section – Information to be collected applies to the patient/victim of the chemical incident.**

**LAST NAME** \_\_\_\_\_

**DOB/AGE** (DOB preferred) \_\_\_\_\_

- RACE** (Check one)
- White
  - Black
  - Asian
  - Native Hawaiian/Pacific Islander
  - American Indian/Alaskan Native
  - Other

**FIRST NAME** \_\_\_\_\_

- SEX**
- Male
  - Female
  - Unk

**WEIGHT**

**MIDDLE NAME** \_\_\_\_\_

**VICTIM CATEGORY** (Check one)

- General Public
- Employee
- Student
- EMS/Prehospital
- Hospital Personnel
- Employee/industry responder
- Public health responder
- Responder (unspecified)
- Police officer
- Firefighter (unspecified)
- Volunteer firefighter

**HAZMAT RESPONDER**

- Yes
- No
- Unk

**LANGUAGE**

- English
- Other

**ETHNICITY**

- Non-Hispanic
- Hispanic

**WEARING PPE**

- Yes (indicate type below)
- No
- Unk

**TYPE:** (Check all that apply)

**RESPIRATOR**

- SCBA
- PAPR
- PAPR w/ escape SCBA

**CLOTHING**

- encapsulating chemical-protective suit
- hooded chemical-resistant clothing
- chemical-resistant overalls
- two-piece chemical-splash suit
- disposable chemical-resistant overalls
- nonresistant coveralls
- nonresistant work uniform

**GLOVES**

- outer chemical-resistant
- inner chemical-resistant

**BOOTS**

- boot covers-outer chemical-resistant
- boots/shoes chemical-resistant

Patient Contact Information		
<b>HOME ADDRESS STREET</b> _____		
<b>CITY</b> _____	<b>COUNTY</b> _____	<b>ZIP</b> _____
<b>HOME PHONE</b> _____	<b>WORK PHONE</b> _____	
<b>EMPLOYER</b> _____	<b>JOB DUTY</b> _____	
<b>WORK/JOBSITE ADDRESS STREET</b> _____		
<b>CITY</b> _____	<b>COUNTY</b> _____	<b>ZIP</b> _____
Alternate Contact Information – For additional/follow-up information		
<b>FIRST NAME</b> _____	<b>LAST NAME</b> _____	
<b>HOME ADDRESS STREET</b> _____		
<b>CITY</b> _____	<b>COUNTY</b> _____	<b>ZIP</b> _____
<b>HOME PHONE</b> _____	<b>RELATIONSHIP TO VICTIM</b> _____	

**Patient/Victim Clinical History**

**MEDICAL INFORMATION**

**FROM** (check all that apply)  Victim  Informant(s)  Medical records review  Healthcare provider  Other (specify) \_\_\_\_\_

**EXPOSURE RELATED SIGNS AND SYMPTOMS** (Check the appropriate signs and symptoms)

<p><b>Breathing or Respiratory</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Irritation of nose, airways</li> <li><input type="checkbox"/> Dry mouth</li> <li><input type="checkbox"/> Runny nose</li> <li><input type="checkbox"/> Nosebleed</li> <li><input type="checkbox"/> Sneezing</li> <li><input type="checkbox"/> Increase in breathing rate</li> <li><input type="checkbox"/> Chest tightness</li> <li><input type="checkbox"/> Wheezing</li> <li><input type="checkbox"/> Shortness of breath</li> <li><input type="checkbox"/> Difficulty breathing</li> <li><input type="checkbox"/> Respiratory arrest</li> <li><input type="checkbox"/> Laryngeal spasm</li> <li><input type="checkbox"/> Pulmonary edema</li> <li><input type="checkbox"/> Pulmonary infiltrate</li> </ul>	<p><b>Cough:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> hacking cough</li> <li><input type="checkbox"/> productive cough</li> <li><input type="checkbox"/> cough w/ foamy sputum</li> </ul> <p><b>Skin</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pink or red coloration</li> </ul> <p><b>Irritation:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> burning</li> <li><input type="checkbox"/> itching</li> </ul> <p><b>Blisters</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cyanosis</li> </ul> <p><b>Neurological</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Headache</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Decreased memory, concentration</li> <li><input type="checkbox"/> Confusion</li> <li><input type="checkbox"/> Altered mood (giddiness, anxiety)</li> <li><input type="checkbox"/> Intoxication</li> <li><input type="checkbox"/> Hallucination</li> <li><input type="checkbox"/> Sudden loss of consciousness</li> <li><input type="checkbox"/> Coma</li> <li><input type="checkbox"/> Cramping</li> <li><input type="checkbox"/> Muscle twitching/tremors</li> <li><input type="checkbox"/> Ataxia</li> <li><input type="checkbox"/> Convulsions</li> <li><input type="checkbox"/> Flaccid paralysis</li> <li><input type="checkbox"/> Copious/involuntary secretions</li> <li><input type="checkbox"/> Drooling</li> <li><input type="checkbox"/> Localized sweating</li> </ul>	<p><b>Eye or Vision</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Tearing</li> <li><input type="checkbox"/> Itchy</li> <li><input type="checkbox"/> Burning</li> <li><input type="checkbox"/> Conjunctivitis</li> <li><input type="checkbox"/> Corneal opacity</li> <li><input type="checkbox"/> Physical damage</li> <li><input type="checkbox"/> Constricted pupils</li> <li><input type="checkbox"/> Dilated pupils</li> <li><input type="checkbox"/> Fixed pupils</li> <li><input type="checkbox"/> Blurred/dim/lack of vision</li> </ul> <p><b>Gastrointestinal</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of appetite</li> <li><input type="checkbox"/> Nausea</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Diarrhea</li> </ul> <p><b>Cardiac</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hypotension</li> <li><input type="checkbox"/> Palpitations</li> <li><input type="checkbox"/> Arrhythmia</li> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Cardiac arrest</li> </ul> <p><b>Immune</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Neutropenia</li> </ul> <p><b>Trauma</b> (note others)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Laceration</li> <li><input type="checkbox"/> Fracture</li> <li><input type="checkbox"/> Burn</li> </ul>
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**OTHER SYMPTOMS, MEDICAL DX, TRAUMA** (Describe)

**MDCH Chemical Event Epidemiologic Data Collection Form – Patient/Victim**

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**Additional Patient/Victim Information Section – Information to be collected applies to the patient/victim of the chemical incident.**

**VICTIM DECONTAMINATION** (Check one)

- Victim was not decontaminated
- Decontaminated on scene
- Decontaminated at medical facility
- Both on scene and at medical facility

**ONSET OF IDENTIFIED SYMPTOMS**

**DATE** \_\_\_\_\_ **HOUR** \_\_\_\_\_ am  
pm

**DURATION OF IDENTIFIED SYMPTOMS**

days  
weeks  
months

**FATAL ILLNESS** (Check one)

- Yes
- No
- Unk

**DATE OF DEATH** (If fatal) \_\_\_\_\_

**RESIDUAL SYMPTOMS** (Describe):

**HEALTHCARE RECEIVED**

**TYPE** (Check one)

- ED – outpatient
- Hospital – inpatient
- Urgent care facility
- Private physician

**TREATING PHYSICIAN**

**NAME** \_\_\_\_\_

**PHONE** \_\_\_\_\_

**FACILITY NAME** \_\_\_\_\_

**STREET ADDRESS** \_\_\_\_\_

**CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_

**EXPOSURE SPECIFIC TREATMENT RECEIVED** (Describe):

**Patient/Victim Laboratory Information and Case Status – Laboratory information if gathered and available.**

**SPECIMEN 1**

**TYPE** (Check one)

- Stool
- Urine
- Blood
- Vomitus
- Skin swab
- CSF

**LAB NAME** \_\_\_\_\_

**SPECIMEN NUMBER** \_\_\_\_\_

**DATE COLLECTED** \_\_\_\_\_

**RESULT:**

**SPECIMEN 2**

**TYPE** (Check one)

- Stool
- Urine
- Blood
- Vomitus
- Skin swab
- CSF

**LAB NAME** \_\_\_\_\_

**SPECIMEN NUMBER** \_\_\_\_\_

**DATE COLLECTED** \_\_\_\_\_

**RESULT:**

**SPECIMEN 3**

**TYPE** (Check one)

- Stool
- Urine
- Blood
- Vomitus
- Skin swab
- CSF

**LAB NAME** \_\_\_\_\_

**SPECIMEN NUMBER** \_\_\_\_\_

**DATE COLLECTED** \_\_\_\_\_

**RESULT:**

**CASE STATUS** (Check one)

- Confirmed case - A clinically compatible case with confirmatory laboratory results.
- Presumptive case - A clinically compatible case with presumptive laboratory results.
- Suspected case - A clinically compatible case without presumptive or confirmatory laboratory results.
- Not a case

**Patient/Victim Notes – Additional notes, narrative, or distinguishing characteristics about the victim or incident.**

**NOTES:**

Pre-existing conditions, Allergies, Medications:

**Additional Cases - Persons in household presenting with similar symptoms.**

**FIRST NAME** \_\_\_\_\_ **LAST NAME** \_\_\_\_\_ **DATE OF ONSET** \_\_\_\_\_

**FIRST NAME** \_\_\_\_\_ **LAST NAME** \_\_\_\_\_ **DATE OF ONSET** \_\_\_\_\_

**FIRST NAME** \_\_\_\_\_ **LAST NAME** \_\_\_\_\_ **DATE OF ONSET** \_\_\_\_\_

**CONFIDENTIAL DATA**

(Continued next page)

Edited: 07/05

**Victim Specific Event Information**

**NUMBER OR DESCRIPTION OF ASSOCIATED EVENT**

**DESCRIPTION** (If event number unknown)

**EVENT NUMBER** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (county code - year - event)

**VICTIM'S LOCATION AND PRECAUTIONS**

**VICTIM PROXIMITY TO RELEASE POINT** (Check one)

- Immediate area where release occurred/<10 ft
- Wing/section of building/11-50 ft
- Building/51-100 ft
- Facility/101 - 200 ft
- 200ft - 1/4 mi
- 1/4 mi - 1/2 mi
- 1/2 mi - 1 mi
- >1 mi
- Unknown release point
- Unknown location at time of release

**VICTIM LOCATION**

**AT TIME OF RELEASE** (Check one)

- Outside
- Home
- In vehicle
- Commercial building
- Industrial building
- Other (specify) \_\_\_\_\_
- Unknown release point
- Unknown location at time of release

**PRECAUTIONS TAKEN**

(Check all that apply)

- None
- Ventilation shut down
- Shelter in place
- PPE
- Unknown
- Other (specify) \_\_\_\_\_

**NOTES** (Additional details about proximity, environment and precautions)

**Victim Exposure to Substance**

**PHYSICAL STATE OF SUBSTANCE**

- Powder
- Gas
- Liquid
- Solid
- Aerosol
- Unknown

**ROUTE OF EXPOSURE**

(Check all that apply)

- Skin
- Inhalation
- Ingestion
- Injection
- No direct contact
- Unknown

**ESTIMATED DURATION OF EXPOSURE**

\_\_\_\_\_ sec  
 \_\_\_\_\_ min  
 \_\_\_\_\_ hour(s)  
 \_\_\_\_\_ day(s)

**INFORMATION OR INSTRUCTIONS PROVIDED POST-EXPOSURE**

- Fact sheet
- Verbal instructions
- Sought own information
- None

**ENVIRONMENTAL SAMPLES TO DOCUMENT EXPOSURE** (If yes, document type and result)

- Yes
- No
- Unk

ENVIRONMENTAL SAMPLE 1	ENVIRONMENTAL SAMPLE 2	ENVIRONMENTAL SAMPLE 3
DATE _____	DATE _____	DATE _____
LOCATION _____	LOCATION _____	LOCATION _____
TYPE _____	TYPE _____	TYPE _____
RESULT:	RESULT:	RESULT:

**NOTES** (Additional event, exposure or environmental sampling information)