PHYSICIAN'S CONFIDENTIAL REPORT OF KNOWN OR SUSPECTED PESTICIDE-RELATED ILLNESS

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

Patient's Last Name* | Social Security Number | Birth Date* (Month / Day / Year)

First Name* | Middle Name (or Initial) | Age Units

Address: Number, Street* | Apt/Unit Number

City/Town* | State* | ZIP Code* | County*

Home Telephone* ( ) | Cellular Telephone* ( ) | Gender* ❑Male ❑ Female ❑ Unknown

Work Telephone ( ) | Occupation

Ethnicity* (check one)
- ❑ Hispanic or Latino
- ❑ Not Hispanic or Latino
- ❑ Unknown

Race* (check one or more)
- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Asian Indian
- ❑ Black or African American
- ❑ Filipino
- ❑ Guamanian
- ❑ Native Hawaiian/Other Pacific Islander
- ❑ Samoan
- ❑ White
- ❑ Other Race:
- ❑ Unknown

Reporting Provider - Last Name* | First Name* | Telephone Number* ( )

Reporting Health Care Facility* | FAX Number ( )

Address: Number, Street | Suite Number | Submitted by*

City | State | ZIP Code | Date Submitted* (Month / Day / Year)

Illness Onset Date (Month / Day / Year) | Initial Examination Date* (Month / Day / Year) | List Any Pre-existing Conditions, If Known (e.g., allergies, asthma, pregnancy, etc)

Signs and Symptoms* (check all that apply)

Dermatologic
- ❑ Blistering
- ❑ Burns
- ❑ Edema
- ❑ Erythema (redness)
- ❑ Irritation/Pain
- ❑ Pruritis (itching)
- ❑ Rash
- ❑ Other_____

Gastrointestinal
- ❑Abdominal pain/cramping
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting
- ❑ Other: _____

Neurologic/Sensory
- ❑ Anxiety/Irritability
- ❑ Ataxia (incoordination)
- ❑ Confusion
- ❑ Depressed consciousness/Coma
- ❑ Diaphoresis (profuse sweating)
- ❑ Dizziness
- ❑ Fasciculation (muscle twitching)
- ❑ Headache
- ❑ Muscle pain/cramping
- ❑ Muscle weakness
- ❑ Numbness/Tingling
- ❑ Salivation
- ❑ Seizure
- ❑ Tremors
- ❑ Other: _____

Ocular
- ❑ Blurred vision
- ❑ Corneal abrasion
- ❑ Irritation/Pain
- ❑ Lacrimation (tearing)
- ❑ Miosis (pinpoint pupils)
- ❑ Photophobia
- ❑ Other_____

Respiratory
- ❑ Cough
- ❑ Dyspnea (shortness of breath)
- ❑ Rhinitis (runny nose)
- ❑ Upper respiratory irritation/Pain
- ❑ Wheezing
- ❑ Other: _____

Other Systemic
- ❑ Chest pain
- ❑ Excessive urination
- ❑ Fatigue
- ❑ Fever/Hyperexia
- ❑ Malaise
- ❑ Tachycardia
- ❑ Other_____

❑ Asymptomatic

❑ Pesticide-related death
Date of Death: (Month / Day / Year)

Were Diagnostic or Laboratory Tests Conducted? No | Yes, Completed | Yes, Pending

Treatment Rendered*

If Completed or Pending, Please Describe:

Test:

Medical Diagnosis

Results (indude reporting units):

Normal range or baseline used:

Remarks (Include physician observations, or other detail relevant to the case, not provided above. Additional pages may be attached.)

Pesticide Exposure Date			Name of Pesticide(s) or Active Ingredient(s)*
Month	Day	Year	❑ Unknown

Location Where Pesticide Exposure Occurred (please provide street address, cross streets, or other appropriate detail)*

County of Exposure*	Describe How Patient Was Exposed to Pesticide (e.g., drift, direct spray, environmental residue, spill, ingestion)

Did Exposure Occur at Work?*	If Yes, Name of Patient's Employer	Name of Patient's Supervisor
❑ Yes ❑ No ❑ Unknown		

Patient's Activity When Pesticide Exposure Occurred (Check one)

Mixing/loading/applying pesticide	Transporting/storing/disposing of pesticide
Field work	Routine indoor activity not involved with pesticide application
Flagging	Routine outdoor activity not involved with pesticide application
Maintaining/repairing pesticide application equipment	Emergency response
Manufacturing/formulating pesticide	Other
Packing/processing agricultural commodities	Unknown

Were Others Exposed?	Additional Detail on Pesticide Exposure Incident
❑ Yes ❑ No ❑ Unknown	

Reporting Agency Name*

Street Address Suite Number

City	State	ZIP Code	County

Telephone Number	FAX Number	Date Reported*			Person Filing Report with State
		Month	Day	Year	
( )	( )				

Definition of a Pesticide Illness

A pesticide illness case is a patient who ***is or may be*** suffering from pesticide poisoning or any disease or condition caused by a pesticide. The term ***pesticide*** includes any product intended to repel, kill, prevent, destroy, control, or mitigate any pest. Pesticides include insecticides, herbicides, plant growth regulators, rodenticides or other vertebrate control agents, repellents, dessicants, fungicides, miticides, disinfectants, sterilants, and sanitizers.

Reporting Requirement

Physicians are required to report known or suspected pesticide-related illness to the local health officer within 24 hours (Code of Maryland Regulations 10.06.01). Reports can be made on line or by phone, mail, or fax to:

Environmental Health Coordination Program
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 327
Baltimore, MD 21201
(410) 767-6234 (Voice)
(410) 333-5995 (Fax)

Confidential Patient Medical Information Requirements

This document contains confidential medical information, subject to federal and state law. Submission as prescribed will not violate the Health Insurance Portability and Accountability Act of 1996, or HIPAA (Pub. L. 104-191; 45 CFR Part 160 and Part 164, Subparts A and E).

Reporting of known or suspected pesticide illness is mandatory. Use of this exact form is not required, but it is provided for data standardization.

For additional forms, please visit: www.dhmh.state.md/eh/pesticides

Thank-you for reporting a known or suspected pesticide-related illness!