

Carbon Monoxide

Agency: _____

Investigator: _____

Phone number: _____

STATE ONLY

Status: Confirmed Probable
 Suspect Not a case
 Exposure
 Reviewer initials: _____
 Referred to another state: _____

CASE

Last name: _____
 First and middle name: _____
 Maiden name: _____ Suffix: _____
 Address line: _____
 Zip: _____ City: _____
 State: _____ County: _____
 Phone: ()- - Type: _____
 Long-term care resident: Yes No Unknown
 Facility name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____
 Gender: Female Male Other _____
 Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____
 Marital status: Single Married Divorced Parent with partner Separated Widowed
 Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian
 Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
 Parent/Guardian name: _____
 Parent/Guardian phone: ()- - Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____
 Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown
 Outbreak related: Yes No Unknown
 Outbreak name: _____
 Exposure setting: _____
 Epi-linked: Yes No Unk To whom: _____
 Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown
 State: _____ Country: _____

Healthcare provider information

Last name: _____
 First name: _____
 Provider title: ARNP MD DO NP PA
 Facility name: _____
 Address line 1: _____
 Address line 2: _____
 Zip code: _____ City: _____
 State: _____ County: _____
 Phone : ()- - Type: _____

LABORATORY FINDINGS

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____
 Date received: ____ / ____ / ____ Specimen source: Blood Result type: Preliminary Final
 Test Type: _____ Test Result: _____
 Percent: _____ Result date: ____ / ____ / ____ Result: High Out of Range
 Low See Notes

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____
 Date received: ____ / ____ / ____ Specimen source: Blood Result type: Preliminary Final
 Test Type: _____ Test Result: _____
 Percent: _____ Result date: ____ / ____ / ____ Result: High Out of Range
 Low See Notes

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____
 Date received: ____ / ____ / ____ Specimen source: Blood Result type: Preliminary Final
 Test Type: _____ Test Result: _____
 Percent: _____ Result date: ____ / ____ / ____ Result: High Out of Range
 Low See Notes

OCCUPATIONS

Is the case employed, enrolled in school, or attending a child care facility? Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

(Complete the following sections for each known occupation)

Occupation #1:		Job title:			
Worked after symptom onset:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name:			
Date worked from:	/ /	Address:			
Date worked to:	/ /	Zip code:			
Removed from duties:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City:	State:	County:	
Date removed:	/ /	Phone:	()- - Type:		
Handle food:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Attend or provide child care:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Attend school:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type:			
Work in a lab setting:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				

Occupation #2:		Job title:			
Worked after symptom onset:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name:			
Date worked from:	/ /	Address:			
Date worked to:	/ /	Zip code:			
Removed from duties:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City:	State:	County:	
Date removed:	/ /	Phone:	()- - Type:		
Handle food:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Attend or provide child care:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Attend school:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type:			
Work in a lab setting:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: _____ / _____ / _____	Discharge date: _____ / _____ / _____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

CLINICAL INFO & DIAGNOSIS

Reporting source: Laboratory Physician Poison Control Self diagnosis

List any pre-existing medical conditions: _____

Symptoms	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Difficulty walking or doing tasks	<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Nausea	<input type="checkbox"/> Visual changes
	<input type="checkbox"/> Agitation	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headache	<input type="checkbox"/> Numbness	<input type="checkbox"/> Vomiting
	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Drowsiness	<input type="checkbox"/> Impaired judgment	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Weakness
	<input type="checkbox"/> Confusion	<input type="checkbox"/> Fainting	<input type="checkbox"/> Light-headedness	<input type="checkbox"/> Seizure	<input type="checkbox"/> Wheezing
	<input type="checkbox"/> Death	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Other:
	<input type="checkbox"/> Depression	<input type="checkbox"/> Flu-like symptoms	<input type="checkbox"/> Memory problems or loss	<input type="checkbox"/> Stomach pain	

Health Impact: <input type="checkbox"/> Fatal <input type="checkbox"/> Non-fatal <input type="checkbox"/> Not Followed <input type="checkbox"/> Unable to follow <input type="checkbox"/> Unrelated effect
If Non-Fatal: <input type="checkbox"/> Major <input type="checkbox"/> Moderate <input type="checkbox"/> Minor <input type="checkbox"/> No effect If Not Followed: <input type="checkbox"/> Judged Nontoxic <input type="checkbox"/> Minimal effect possible
Was educational information provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
What was the time missed from work/school or daily activities? <input type="checkbox"/> < 24 hours <input type="checkbox"/> 1-2 days <input type="checkbox"/> 3-5 days <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> 2-3 weeks <input type="checkbox"/> > 3 weeks <input type="checkbox"/> > 1 month <input type="checkbox"/> > 2 months <input type="checkbox"/> > 3 months <input type="checkbox"/> > 6 months <input type="checkbox"/> > 1 year
Current smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If no, did you smoke in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, date quit: / /
What resources were used by the patient? <input type="checkbox"/> None known <input type="checkbox"/> Treated on site <input type="checkbox"/> Work clinic or nurse <input type="checkbox"/> 911 Call <input type="checkbox"/> Poison Control Call <input type="checkbox"/> ED Only <input type="checkbox"/> Visit to Physician/med provider <input type="checkbox"/> Hospitalization

Exposure #2		Exposure Date: / /		Exposure Time:	
Location <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Farm, ranch, acreage <input type="checkbox"/> Orchard or Garden <input type="checkbox"/> Community Building <input type="checkbox"/> Community Outdoor Site or Recreation <input type="checkbox"/> Travel out of area <input type="checkbox"/> Commercial Building <input type="checkbox"/> Unknown	Name of Location:				
	Address:				
	Zip code:		Phone:	- -	
	Travel location:				
	Travel departure:		/ /	Travel return:	/ /
Reason for exposure: <input type="checkbox"/> Hobby or small market work <input type="checkbox"/> Work exposure <input type="checkbox"/> Secondary Work Exposure (Take home poisoning) <input type="checkbox"/> Volunteer or unpaid work <input type="checkbox"/> Other: _____	If Reason for exposure= Work exposure or Secondary Work Exposure , complete the following:				
Employment Status <input type="checkbox"/> Self-employed <input type="checkbox"/> Employed by other	Work Category <input type="checkbox"/> Agriculture, Forestry, Fishing and Hunting <input type="checkbox"/> Mining, Quarrying, and Oil and Gas Extraction <input type="checkbox"/> Utilities <input type="checkbox"/> Construction <input type="checkbox"/> Manufacturing <input type="checkbox"/> Wholesale Trade <input type="checkbox"/> Retail Trade <input type="checkbox"/> Transportation and Warehousing <input type="checkbox"/> Information sector <input type="checkbox"/> Finance and Insurance		<input type="checkbox"/> Real Estate and Rental and Leasing <input type="checkbox"/> Professional, Scientific, and Technical <input type="checkbox"/> Management of Companies and Enterprises <input type="checkbox"/> Administrative and Support and Waste <input type="checkbox"/> Management and Remediation Services <input type="checkbox"/> Educational Services <input type="checkbox"/> Health Care and Social Assistance <input type="checkbox"/> Arts, Entertainment, and Recreation <input type="checkbox"/> Accommodation and Food Services <input type="checkbox"/> Public Administration		
Was the exposure intentional? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Were others exposed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is this what the patient suspects as the reason for poisoning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is this what the medical provider suspects as the reason for poisoning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is this what another source suspects as the reason for poisoning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Total number of exposed: _____ If yes, what source? _____			
Comments:					

Exposure #3		Exposure Date: / /		Exposure Time:	
Location <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Farm, ranch, acreage <input type="checkbox"/> Orchard or Garden <input type="checkbox"/> Community Building <input type="checkbox"/> Community Outdoor Site or Recreation <input type="checkbox"/> Travel out of area <input type="checkbox"/> Commercial Building <input type="checkbox"/> Unknown	Name of Location:				
	Address:				
	Zip code:		Phone:	- -	
	Travel location:				
	Travel departure:		/ /	Travel return:	/ /
Reason for exposure: <input type="checkbox"/> Hobby or small market work <input type="checkbox"/> Work exposure <input type="checkbox"/> Secondary Work Exposure (Take home poisoning) <input type="checkbox"/> Volunteer or unpaid work <input type="checkbox"/> Other: _____	If Reason for exposure= Work exposure or Secondary Work Exposure , complete the following:				
Employment Status <input type="checkbox"/> Self-employed <input type="checkbox"/> Employed by other	Work Category <input type="checkbox"/> Agriculture, Forestry, Fishing and Hunting <input type="checkbox"/> Mining, Quarrying, and Oil and Gas Extraction <input type="checkbox"/> Utilities <input type="checkbox"/> Construction <input type="checkbox"/> Manufacturing <input type="checkbox"/> Wholesale Trade <input type="checkbox"/> Retail Trade <input type="checkbox"/> Transportation and Warehousing <input type="checkbox"/> Information sector <input type="checkbox"/> Finance and Insurance		<input type="checkbox"/> Real Estate and Rental and Leasing <input type="checkbox"/> Professional, Scientific, and Technical <input type="checkbox"/> Management of Companies and Enterprises <input type="checkbox"/> Administrative and Support and Waste <input type="checkbox"/> Management and Remediation Services <input type="checkbox"/> Educational Services <input type="checkbox"/> Health Care and Social Assistance <input type="checkbox"/> Arts, Entertainment, and Recreation <input type="checkbox"/> Accommodation and Food Services <input type="checkbox"/> Public Administration		
Was the exposure intentional? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Were others exposed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is this what the patient suspects as the reason for poisoning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is this what the medical provider suspects as the reason for poisoning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is this what another source suspects as the reason for poisoning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Total number of exposed: _____ If yes, what source? _____			
Comments:					

