

Methemoglobinemia

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 Urine 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 Urine 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 Urine 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

- Anxiety
- Bluish appearance of the skin
- Confusion
- Developmental delay
- Failure to thrive
- Fatigue
- Frustrated easily
- Headache
- Irritation
- Lack of energy
- Mental retardation
- Personality changes
- Psychological symptoms
- Seizures
- Shortness of breath
- Short-term memory loss
- Other:

Health Impact: <input type="checkbox"/> Fatal <input type="checkbox"/> Non-fatal	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

TREATMENT

What was the treatment level? None given or recommended Self ED Patient refused
 Recommended – not done Outpatient Inpatient

EXPOSURES

Has the case been exposed to any of the following in the last 60 days? Yes No Unknown

Complete an exposure table for each known exposure. Attach additional information if necessary.

Exposure List	Recreational water - lake/river Recreational water - swimming pool/spa	Anesthetics - inhaled or dermal Medications	Topical pain meds Contaminated food or drink
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Exposure #1		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	<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	<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	<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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Total number of exposed: _____	
If yes, what source? _____	

Comments:

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:					

Does the case have a drinking water exposure? Yes No Unknown

For each drinking water exposure, complete a drinking water exposure table. Attach additional information if necessary.

Drinking water exposure #1	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 Area <input type="checkbox"/> Travel out of area <input type="checkbox"/> Commercial Building <input type="checkbox"/> Unknown	Drinking water source <input type="checkbox"/> Municipal <input type="checkbox"/> Rural water <input type="checkbox"/> Private well <input type="checkbox"/> Bottled						
		If well water, what was the date of last microbiologic and/or nitrate testing? _____						
		If municipal, rural, or bottled, what is the name of the provider? _____						
		Have there been any recent changes to the: <table style="display: inline-table; vertical-align: top;"> <tr> <td>Taste of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Odor of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Color of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> </table>	Taste of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Odor of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Color of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Taste of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
Odor of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
Color of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							

Drinking water exposure #2	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 Area <input type="checkbox"/> Travel out of area <input type="checkbox"/> Commercial Building <input type="checkbox"/> Unknown	Drinking water source <input type="checkbox"/> Municipal <input type="checkbox"/> Rural water <input type="checkbox"/> Private well <input type="checkbox"/> Bottled						
		If well water, what was the date of last microbiologic and/or nitrate testing? _____						
		If municipal, rural, or bottled, what is the name of the provider? _____						
		Have there been any recent changes to the: <table style="display: inline-table; vertical-align: top;"> <tr> <td>Taste of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Odor of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Color of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> </table>	Taste of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Odor of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Color of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Taste of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
Odor of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
Color of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							

In the last two weeks has the case taken:

Over the counter medicines? Yes No Unknown If yes, list: _____

Prescription medicines? Yes No Unknown If yes, list: _____

Nutritional supplements? Yes No Unknown If yes, list: _____

Herbal supplements? Yes No Unknown If yes, list: _____

Homeopathic medicines? Yes No Unknown If yes, list: _____

Illicit drugs? Yes No Unknown If yes, list: _____

Has the case recently had a medical procedure that required a local anesthetic? Yes No Unknown

If yes: What is the name of the provider? _____

What anesthetic was used? _____

FOR FINAL DETERMINATION ONLY:

Based on this investigation what was the primary determination for the source of the exposure?

<input type="checkbox"/> Recreational water - lake/river	<input type="checkbox"/> Anesthetics - inhaled or dermal	<input type="checkbox"/> Topical pain meds
<input type="checkbox"/> Recreational water - swimming pool/spa	<input type="checkbox"/> Medications	<input type="checkbox"/> Contaminated food or drink

Secondary source (if applicable):

<input type="checkbox"/> Recreational water - lake/river	<input type="checkbox"/> Anesthetics - inhaled or dermal	<input type="checkbox"/> Topical pain meds
<input type="checkbox"/> Recreational water - swimming pool/spa	<input type="checkbox"/> Medications	<input type="checkbox"/> Contaminated food or drink

Was the exposure associated with an incident or natural disaster? Yes No Unknown

NOTES:
