

PESTICIDE EXPOSURE ASSESSMENT

To be filled out during clinical assessment. Health provider – ask these questions verbally



Patient ID

Full Name: _____ Male Female
Last First

DOB: _____ Occupation: _____ Employer: _____

Address: _____
Street Address Apartment/Unit # City State ZIP Code

Exposure Information

Name of pesticide (active ingredients, concentration & EPA registration number):

Circumstances:

- Intentional
- Accidental
- Occupational
- Non-occupational

Exposure route:

- Dermal
- Ocular
- Oral
- Respiratory

Amount, if ingested: _____

Concentrate or dilution: _____

Crop (if applicable): _____

Other exposure details (eg. spill?, drift?, early reentry?):

Method of pesticide application:

- Aerial
- Backpack sprayer
- Hand sprayer
- Boom sprayer
- Air blast

Other: _____

Other individuals involved (also exposed, witnessed, assisted)? Yes No

Who? _____

If worker, had patient received Worker Protection Standard training? Yes No

Symptoms

- | | | | |
|----------------------------------------------|-------------------------------------------|------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Drooling | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Skin rash | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Red eyes |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea | <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Muscle twitches | <input type="checkbox"/> Productive cough | <input type="checkbox"/> Confusion | Other: _____ |

How long after over-exposure did symptoms begin? _____

Length of clinical observation: _____ hrs. _____ min.

Notable changes over observation period (describe): _____

Other workers/persons exposed who developed symptoms? Yes No

Physical Signs

Skin: _____ Eyes: _____

Mucous membranes: _____ Lungs: _____

Heart: _____ (rate, rhythm) Neuro: _____ (pupillary response, distal sensory exam, motor exam, coordination):

Other unique physical findings: _____

Cholinesterase testing: Date: _____ Results: _____

Follow-up test ordered: Yes No Date: _____ Results: _____

Materials Collected & Lab

- Copy of pesticide label/MSDS
- Copy of pesticide application record, if applicable
- Contaminated clothing, hats, foliage from site (place in clean plastic bag; label & seal; freeze)
- Fingernail residue (place in clean plastic bag; label & seal; freeze)
- Saliva sample (seal container, label and freeze)
- Hair sample, if exposed (place in clean plastic bag; label & seal; freeze)
- Wipe of exposed skin (wipe exposed skin with ethanol swab, place swab in plastic bag; label indicating size of area swabbed & seal; freeze)
- Cholinesterase testing (RBC or AChE and Plasma or BuChE or PChE):
 - 10cc whole blood, anticoagulated with sodium heparin (refrigerate)
 - 5cc plasma, anticoagulated with sodium heparin (spin and refrigerate)
 - Other: _____

Treatment

Poison Control 800-222-1222

Skin washed? _____ (time) Clothing removed? _____

Eyes irrigated? _____ (with what, for how long)

GI: emetics, absorbents, other treatments by mouth? _____

Atropine? Yes No Dose: _____ Response: _____

2-PAM? Yes No Dose: _____ Response: _____

Reporting

Reported to:

Agency: _____

Phone number: _____ Website: _____

Provider ID

Provider Signature: _____ Date: _____

Address: _____ Phone: _____