# PESTICIDE EXPOSURE ASSESSMENT

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

## Patient ID

<table>
<thead>
<tr>
<th>Full Name:</th>
<th></th>
<th></th>
<th>□ Male □ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOB:</th>
<th>Occupation:</th>
<th>Employer:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>Street Address</th>
<th>Apartment/Unit #</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
</table>

## Exposure Information

**Pesticide brand name:**

**Active ingredient:**

**EPA registration number:**

**Amount exposed to:**

**Concentrate or dilution:**

**Crop (if applicable):**

**Suspected cause of exposure (eg. spill?, drift? early reentry?)**

**Personal Protective Equipment used?**

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

**Who?**

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

<table>
<thead>
<tr>
<th>Date last trained</th>
</tr>
</thead>
</table>

**Method of pesticide application:**

**Exposure route:**

**Circumstances:**

- □ Intentional
- □ Accidental
- □ Occupational
- □ Non-occupational

## Symptoms

- □ Weakness
- □ Drooling
- □ Blurred vision
- □ Chest pain
- □ Skin rash
- □ Tiredness
- □ Excessive sweating
- □ Red eyes
- □ Headaches
- □ Nausea
- □ Loss of consciousness
- □ Convulsions
- □ Shortness of breath
- □ Dizziness
- □ Vomiting
- □ Abdominal pain
- □ Muscle twitches
- □ Productive cough
- □ Confusion
- □ Other: ________________

How long after 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

---

Migrant Clinicians Network (2014). Adapted with permission from Mark Lyons, MPH, PAC, New Jersey Department of Health. Revised and reviewed by the MCN Environmental and Occupational Health Advisory Committee. This form may be adapted and duplicated as needed. Used with permission from Migrant Clinicians Network. Please mail completed form to: Hawaii Department of Health, 919 Ala Moana Blvd, Room 206, Honolulu, HI 96814
Physical Signs

Skin: ___________________________________________ Eyes: ___________________________________________

Mucous membranes: ______________________________ Lungs: ___________________________________________

Heart: __________________________________________ Neuro: __________________________________________

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

Other unique physical findings: ________________________________________________________________

Cholinesterase testing AChE and BuChE (Sample dictated by testing lab): 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
□ 10cc whole blood, anticoagulated with sodium heparin (refrigerate)
□ 5cc plasma, anticoagulated with sodium heparin (spin and refrigerate)
□ A fresh urine sample (label and freeze)
□ 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 alcohol swab, place swab in plastic bag; label indicating size of area swabbed & seal; freeze)
□ Other: __________________________________________________________

Treatment

Poison Control 800-222-1222

Skin washed? ____________________ Clothing removed? ____________________

(time)

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: ____________________