



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

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? _____

Circumstances:

- Intentional
 Accidental
 Occupational
 Non-occupational

Exposure route:

- Dermal
 Ocular
 Oral
 Respiratory

Method of pesticide application:

- Aerial
 Backpack sprayer
 Hand sprayer
 Boom sprayer
 Air blast

Other: _____

Other individuals involved (also exposed, witnessed, assisted)?

Yes No Who? _____

Date of exposure: _____

If worker, had patient received Worker Protection Standard training? Yes Date last trained _____ 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 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 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? _____ (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: _____