NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Occupational Health and Injury Prevention

Confidential Reporting Form for Suspected or Confirmed Pesticide Poisoning

As required by State Sanitary Code, Part 22.11, every physician, health facility and clinical laboratory in attendance on a person with a confirmed or suspected pesticide poisoning must report such occurrence to the New York State Department of Health within 48 hours. Please provide as much information as possible.

Type or print clearly using blue or black ink.

Date of Report ____/____/____

Patient Information

Name _____
Last Name First Name MI

Address _____
Number and Street Name Apt #

_____
City/Town County State Zip Code

Phone Number ( ) - ( ) -
Home Phone Number Cell Phone Number

Date of Birth ____/____/____

Gender ☐ Male ☐ Female

Race ☐ White ☐ Black ☐ American Indian / Alaskan Eskimo ☐ Asian / Pacific Islander ☐ Mixed ☐ Other

Hispanic ☐ Yes ☐ No

Does the patient speak English? ☐ Yes ☐ No If not, what is the patient's primary language? _____

Exposure Information

Date of Exposure / Event (or approx. date) ____/____/____ Time of Exposure ____:____ ☐ a.m. ☐ p.m.

Symptom Onset Date ____/____/____ Time of Symptom Onset ____:____ ☐ a.m. ☐ p.m.

Please describe how the patient was exposed _____

_____

Was anyone else exposed? ☐ Yes ☐ No _____

Was anyone else treated due to their exposure? ☐ Yes ☐ No

Did the exposure occur at work? ☐ Yes ☐ No (if yes please complete employer information)

Employer Name _____
Employer Address (including suite number) City State Zip Code

Phone Number ( ) -

What was the chemical/name(s) of the product the patient was exposed to (if known)? _____

EPA Registration Number (can be found on product label) _____

EPA Registration Number _____

Reporting Physician

Name _____ Phone Number ( ) -

Address _____
Number and Street Name, including Suite # City State Zip Code

Reporting Health Care Facility or Clinical Laboratory

Facility Name _____ Phone Number ( ) -

Address _____
Number and Street Name City State Zip Code

Other Contact Information

If you would like us to contact someone other than the reporting physician please indicate in the space provided below.

Persons Name _____ Phone Number ( ) -

Title _____

Health and Medical Information (Signs and Symptoms)

Level of Treatment (check all that apply)

☐ Office Visit ☐ Hospitalization ☐ Emergency Room Visit ☐ Clinical Visit ☐ Other (e.g. Advise from Poison Control Center)

Date(s) of Treatment ____/____/____ to ____/____/____

Signs observed by treating physician _____

_____

Symptoms reported by patient to _____

_____

ICD-9 Code / Diagnosis Description _____ ICD-9 Code / Diagnosis Description _____

ICD-9 Code / Diagnosis Description _____ ICD-9 Code / Diagnosis Description _____

Pre-existing conditions (check all that apply)

☐ Allergies ☐ Asthma ☐ Pregnancy ☐ Acquired Chemical Intolerance (ACI) ☐ Other _____

Additional Comments on Health Effects

_____

_____

Please send this completed form to:

Bureau of Occupational Health and Injury Prevention
NYS Department of Health
Corning Tower, Room 1325
Empire State Plaza
Albany, NY 12237

or fax to: (518) 402-7909

Questions: Telephone: (518) 402-7900
E-mail: boh@health.state.ny.us

You may also report suspected or confirmed pesticide poisoning by calling 1-800-322-6850

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