PESTICIDE EXPOSURE ASSESSMENT

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

MIGRANT CLINICIANS NETWORK MCN

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? _____

If worker, had patient received Worker Protection Standard training? ☐ Yes Date last trained _____ ☐ No

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

For more information, contact MCN (512) 327-2017 www.migrantclinician.org

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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: _____