Tennessee Department of Health Carbon Monoxide Poisoning Case Report Form

Please complete this form. Provide as much supplemental information as is necessary to assist the investigation and data entry process. If you have any questions, please call 615-741-7247 and ask for the Carbon Monoxide Epidemiologist.

Return this form to the TN Dept of Health via FAX: 615-741-3857, ATTN: Carbon Monoxide Surveillance

Patient Demographics

Last Name: _____ **First:** _____ **MI:** _____ **DOB:** ___/___/_____

Reported Age: _____ ☐ Days ☐ Months ☐ Years **Sex:** ☐ Male ☐ Female ☐ Unknown

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Ethnicity: ☐ Hispanic ☐ Not Hispanic **Race:** ☐ American Indian / Alaskan ☐ Hawaiian / Pacific Islander ☐ Asian ☐ White ☐ Black / African American ☐ Other (_____)

Description of Exposure

Exposure Event

Onset Date: ___/___/_____

Poisoning Intent:

☐ Unintentional

☐ Intentional

If Intentional:

Suicide? ☐ Yes ☐ No

Site of Exposure

☐ Residential *(private home except workplace)*

☐ Commercial

☐ Industrial *(NTSIP)*

☐ Occupational *(workplace)*

☐ Recreational *(park/campsite/water)*

☐ Other: _____

Type of Exposure

☐ Appliance ☐ Automobile/RV

☐ Boat ☐ Generator

☐ Smoke/Fire ☐ Power Tools

☐ Space Heater

☐ Other: _____

Clinical Information

Risk Factors

Is the patient pregnant?

☐ Yes ☐ No ☐ N/A

Does the patient smoke?

☐ Yes ☐ No ☐ Unknown

Hospitalization

Was Patient Hospitalized? ☐ Yes ☐ No

If Applicable:

Date of Admission: ___/___/_____

Date of Discharge: ___/___/_____

Outcome

Medical Outcome: ☐ Recovered ☐ Died

If Applicable:

Date of Death: ___/___/_____

Signs & Symptoms (Check all that apply)

☐ Agitation ☐ Chest Pain ☐ Confusion ☐ Dizziness ☐ Drowsiness ☐ Fatigue ☐ Headache ☐ Nausea

☐ Numbness ☐ Palpitation ☐ Stomach Pain ☐ Vomiting ☐ Weakness ☐ Wheezing ☐ Shortness of Breath

☐ Loss of Consciousness ☐ Other(s): _____

Laboratory Data

Was a Lab Test Performed? ☐ Yes ☐ No *If Yes, **COHb** Level:* _____% ☐ Blood ☐ Pulse Oximetry **Date Collected**: ___/___/_____

Comments

_____

_____

_____

Report Information

Date of Report: ___/___/_____ **Person Reporting:** _____

Organization: _____ **Phone:** _____

For Administrative Use Only:

Investigation Summary

Investigation Start Date: ___/___/_____

Investigation Status: ☐ Open ☐ Closed

Case Status: ☐ Confirmed ☐ Probable ☐ Suspect

Case Classification Criteria:

☐ COHb ☐ Diagnosis ☐ PCC ☐ Records ☐ ENV

Event Name *(if applicable)*: _____

Were Environmental Measurements Taken? ☐ Yes ☐ No

If Yes, CO Level: _____ppm *Date :* ___/___/_____

Measurement notes: _____

NBS ID: _____ **PCC Case #:** _____

If applicable:

State ID: _____ **NTSIP:**TN201_____