# Pesticide Exposure Assessment

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

## Patient ID

- **Full Name:**
  - Last
  - First
- **DOB:**
- **Occupation:**
- **Employer:**
- **Address:**
  - Street Address
  - Apartment/Unit #
  - City
  - State
  - ZIP Code

## Exposure Information

- **Name of pesticide (active ingredients, & EPA registration number):**
- **Amount, if ingested:**
- **Concentrate or dilution:**
- **Crop (if applicable):**
- **Other exposure details (eg. spill?, drift? early reentry?):**

## 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**
- **No**

Date last trained ________

## 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 over-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**

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Migrant Clinicians Network (2013). 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.
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: ____________________________