KANSAS CARBON MONOXIDE POISONING REPORTING FORM

Kansas Department of Health and Environment

Fax this form to your local health department or KDHE: 877-427-7318 within 24 hours* of suspecting a case, regardless of laboratory evidence.
Please include disease-specific laboratory results, if available
For questions, call the KDHE Epidemiology Hotline: 877-427-7317
This form is available at: http://www.kdheks.gov/epi/disease_reporting.html

Today's date: _____

PATIENT INFORMATION

Name: _____
Last *First* *Middle*

Mobile phone: _____ **Home phone:** _____

Residential address: _____ **Apartment number:** _____

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

Date of Birth (*if unknown, provide age*): _____

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian / Alaska Native ☐ Native Hawaiian / Pacific Islander

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Sex: ☐ Male ☐ Female → **Pregnant?** ☐ Yes ☐ No ☐ Unknown

EXPOSURE INFORMATION

Date and time of incident: _____ **Time:** ____ : ____ **AM or PM**

Site of exposure: ☐ Public Setting → **Public setting:** ☐ Daycare ☐ Health Care ☐ Hotel ☐ School ☐ Nursing Home ☐ Correctional Facility ☐ Shelter ☐ Restaurant ☐ Other - _____

☐ Residential

Residential: ☐ Single Family Home ☐ Apartment Building ☐ Mobile Dwelling ☐ Duplex/Townhouse

Name and city of site of exposure: _____

Poisoning intent: ☐ Intentional CO poisoning ☐ Unintentional CO poisoning ☐ Unsure

Fire related: ☐ Yes ☐ No ☐ Unsure

DISEASE OR CONDITION INFORMATION

Symptom onset date: _____

Hospitalized? ☐ Yes → **Hospital:** _____ ☐ No ☐ Unknown

Died? ☐ Yes ☐ No

Laboratory name: _____ **Specimen collection date:** _____

Test(s) performed: _____ **Test result(s):** _____

* If the 24 hour reporting period ends on a weekend or a state approved holiday, the report can be made by 5:00pm on the next business day.

(Effective 05/11/2018)

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FACILITY AND PHYSICIAN INFORMATION

Facility name: _____ **Facility city:** _____

Physician name: _____ **Phone #:** _____

Name of person reporting: _____ **Phone #:** _____

TREATMENT INFORMATION

Treated? ☐ Yes → **Treatment type, dosage, and duration:** _____
☐ No
☐ Unknown

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