HARMFUL ALGAL BLOOM (HAB)  
ANIMAL ILLNESS REPORT  
Illinois Department of Public Health  
Communicable Disease Control Section  
Phone: 217-782-2016  Fax: 217-524-0962

Reporting Entity:  
☐ General Public  ☐ Veterinarian  ☐ Poison Control Center  ☐ Biologist  
☐ Local Agency  ☐ State Agency  ☐ Other______________________________________

Contact Name_________________________________ Phone Number__________________ home/work/cell
Address______________________________________________ County_________________________
Animal Owner Name (if not reporting entity)______________________________________________

If reporting a single animal or small group of animals (please fill out a form for each animal):  
Animal Type:  
☐ Domestic  ☐ Stray  ☐ Unknown  
Species:  
☐ Dog (breed/description)________________________  
☐ Cat (breed/description)________________________  
☐ Livestock (type)_______________________________  
☐ Other (describe)______________________________

Animal Characteristics:  
Sex: ☐ Male  ☐ Female  ☐ Unknown  
Age: ______________  
Weight:___________ lbs  

Did the animal receive veterinary care?  
☐ Yes  ☐ No  ☐ Unknown  
If yes: Vet clinic name and address:  
__________________________________________  

Did the animal die?  
☐ Yes  ☐ No  ☐ Unknown  

If reporting a large group of animals (e.g. flock, herd, or school of fish):  
Species:  
☐ Livestock (type)_______________________________  
☐ Birds (type)_______________________________  
☐ Fish (type)_______________________________  
☐ Other (describe)_____________________________  

Number of animals affected____________________  

Did animals receive veterinary care?  
☐ Yes  ☐ No  ☐ Unknown  
If yes: Vet clinic name and address:  
__________________________________________  

Did any animals die?  ☐ Yes  ☐ No  ☐ Unknown  
If yes: What condition were animals found in?  
(check all that apply)  
☐ Fresh  ☐ Scavenged  ☐ Decomposed  
☐ Unknown  

How many dead animals were counted?  
__________________________________________  

Necropsy performed?  ☐ Yes  ☐ No  ☐ Unknown  


**Suspected source of exposure:**

- [ ] Public water body (name and location)_____________________________________________________
- [ ] Home/private water body (name and location)_____________________________________________
- [ ] Drinking water (source/location)_____________________________________________________
- [ ] Other (describe)_____________________________________________________________________

**If exposure source was a water body:**

- Visible algae present: [ ] Yes [ ] No [ ] Unknown
- Odor: [ ] Yes [ ] No [ ] Unknown
- Describe water body color and appearance: _______________________________________________

**Exposure details**

- Routes(s) of exposure:
  - [ ] Inhalation  [ ] Swallowing/Drinking  [ ] Skin contact  [ ] Unknown  [ ] Other______________
- Date(s) of exposure:
  - _____/_____/_______  _____/_____/_______  _____/_____/_______
- Total duration of exposure: _________________minutes/hrs/days

**Symptoms:**

- Onset Date of Symptoms _____/_____/_______  Duration of Symptoms ___________ days

- General:
  - [ ] Fever  [ ] Lethargy  [ ] Loss of appetite  [ ] Difficulty walking

- Respiratory:
  - [ ] Cough  [ ] Wheezing  [ ] Rapid breathing

- Gastrointestinal:
  - [ ] Vomiting  [ ] Diarrhea  [ ] Excessive drooling  [ ] Lip licking/gagging

- Neurologic:
  - [ ] Weakness  [ ] Stumbling  [ ] Behavior change  [ ] Paralysis  [ ] Seizure  [ ] Coma

- Dermal:
  - [ ] Rash  [ ] Itching  [ ] Redness/Swelling

- Other symptoms (please describe)_________________________________________________________________

- Are you aware of other animals that were exposed and became ill? [ ] Yes  [ ] No

  *If yes please describe and provide contact info ____________________________________________________*

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**Please mail or fax completed form to the Illinois Department of Public Health Communicable Disease Control Section. Mailing address: 525 W Jefferson St., Springfield IL 62761. Fax: 217-524-0962**