

HARMFUL ALGAL BLOOM (HAB) HUMAN ILLNESS REPORT

Illinois Department of Public Health
Communicable Disease Control Section
Phone: 217-782-2016 Fax: 217-524-0962



Reporting Entity:

- General Public Health Care Provider Poison Control Center Local Agency
 State Agency Other _____

Contact Name _____ Phone Number _____ home/work/cell

Identifying information for case:

Name _____ Phone Number _____ home/work/cell

Address _____ County _____

Demographic information for case:

Date of Birth ____/____/____ Height: ____' ____" Weight: ____ lbs

Sex:

- Male Female

Ethnicity:

- Hispanic Non-Hispanic

Race:

- American Indian Asian Black White Unknown Other _____

Suspected source of exposure:

Public water body (name and location) _____

Home/private water body (name and location) _____

Food (type) _____

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 _____

Sick or dead animals present (type, number):

Yes No Unknown _____

Activities during exposure to water body:

Swimming Wading Boating Fishing Tubing/skiing Other _____

Exposure details

Suspected route(s) of exposure:

Inhalation Drinking/Swallowing Skin contact Other _____

Date(s) of exposure:

_____/_____/_____ ____/____/_____ ____/____/_____

Total duration of exposure: _____minutes/hrs/days

Symptoms:

Did case seek medical attention? Yes No

Onset Date of Symptoms ____/____/_____ Duration of Symptoms _____ days

General:

Fever Headache Nasal Congestion Fatigue Eye redness/irritation
 Sore throat

Respiratory:

Cough Wheezing Shortness of breath

Gastrointestinal:

Nausea Vomiting Diarrhea

Muscular/skeletal:

Muscle pain Joint pain Difficulty walking

Neurologic:

Numbness Blurred vision Tingling/burning Confusion Paralysis
 Seizures Coma

Dermal:

Rash Blisters Itching

Other symptoms (please describe)_____

Are you aware of other people that were exposed and became ill? Yes No

If yes:

Name and contact information of exposed person(s)_____

Exposure/illness description_____

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