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  ☐ 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 routes(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