HARMFUL ALGAL BLOOM (HAB) HUMAN ILLNESS REPORT

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

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

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 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