Reset Form

HARMFUL ALGAL BLOOM-RELATED HUMAN ILLNESS NOTIFICATION

State Form 55579 (3-14)
INDIANA STATE DEPARTMENT OF HEALTH

State use only
HABISS #_____
Date _____

Identifying Information for Suspected Case

Name _____
Telephone _____
Address _____
_____
County _____
Date of Birth ____/____/_____
mm dd yyyy

Sex ☐ Male ☐ Female
Race ☐ American Indian
☐ Asian/Pacific Islander
☐ Black ☐ White
☐ Multiracial
☐ Unknown
☐ Other (*please specify*_____)
Hispanic ☐ Yes ☐ No
Height _____ft / in / m *(circle one)*
Weight_____lbs / kg *(circle one)*

Environmental Conditions

Visible algae present
☐ Yes ☐ No ☐ Unknown
If yes, what color?_____
Unusual odors
☐ Yes ☐ No ☐ Unknown
Any sick or dead animals?_____
☐ Yes ☐ No ☐ Unknown
If yes species & count:_____
Additional information:_____
_____
_____
_____

Other Exposed People

_____
_____
_____
_____

State use only
Related HABISS #s _____
_____
_____

Notifying Party

☐ General Public ☐ State Agency
☐ Healthcare Provider ☐ County Agency
☐ Other *(specify)*: _____
Contact Name_____
Telephone Number_____

Exposure Information

Date of exposure ____/____/_____
mm dd yyyy

Time ____:____ am/pm to ____:____ am/pm
hh mm hh mm

Activity Exposure

☐ Recreational
☐ Swimming
☐ Wading
☐ Boating
☐ Fishing
☐ Tubing/skiing
☐ Other *(specify)*:_____

☐ Occupational *(specify)*:
_____
_____
_____

Location of Exposure

☐ Home/Private Water body
☐ Public Water body
Name of water body: _____
Location: _____
_____

Route(s) of Exposure

☐ Inhalation ☐ Unknown
☐ Dermal ☐ Other:_____
☐ Ingestion

Source of Exposure

☐ Food *(type, brand, where purchased)*:
_____
☐ Brackish water
☐ Sea water
☐ Fresh water
☐ Drinking water
☐ Other *(specify)*_____

Signs and Symptoms (Onset is from time of first exposure, duration is from time of onset.)
Symptomatic ☐Yes ☐No ☐Unknown

General
☐Fatigue Onset _____ Duration _____
☐Fever Onset _____ Duration _____
☐Loss of appetite Onset _____ Duration _____
☐Malaise Onset _____ Duration _____

Head, Eye, Ear, Nose, Throat
☐Earache Onset _____ Duration _____
☐Headache Onset _____ Duration _____
☐Conjunctivitis Onset _____ Duration _____
☐Nasal congestion Onset _____ Duration _____
☐Sore throat Onset _____ Duration _____
☐Other _____ Onset _____ Duration _____

Respiratory
☐Cough Onset _____ Duration _____
☐Short of breath Onset _____ Duration _____
☐Wheezing Onset _____ Duration _____
☐Chest tightness Onset _____ Duration _____
☐Other _____ Onset _____ Duration _____

Cardiovascular
☐Chest pain Onset _____ Duration _____
☐Irregular beat Onset _____ Duration _____
☐Other _____ Onset _____ Duration _____
☐Cyanosis Onset _____ Duration _____
(*check all that apply*: ☐arms ☐legs ☐mouth
☐Pale (arms/legs) Onset _____ Duration _____

Gastrointestinal
☐Nausea Onset _____ Duration _____
☐Diarrhea Onset _____ Duration _____
☐Other _____ Onset _____ Duration _____
☐Vomiting Onset _____ Duration _____
☐Pain (up R quadrant) Onset _____ Duration _____

Genitourinary
☐Dark urine Onset _____ Duration _____
☐Blood in urine Onset _____ Duration _____
☐Other _____ Onset _____ Duration _____

Musculoskeletal
☐Muscle pain Onset _____ Duration _____
☐Joint pain Onset _____ Duration _____
☐Difficulty walking Onset _____ Duration _____
☐Other _____ Onset _____ Duration _____

Neurologic
☐Confusion Onset _____ Duration _____
☐Memory loss Onset _____ Duration _____
☐Seizure Onset _____ Duration _____
☐Coma Onset _____ Duration _____
☐Other _____ Onset _____ Duration _____
☐Numbness Onset _____ Duration _____
☐Weakness Onset _____ Duration _____
☐Paralysis Onset _____ Duration _____
☐Vertigo Onset _____ Duration _____
☐Tingling/burning Onset _____ Duration _____
☐Vision disturbance Onset _____ Duration _____

Dermal
☐Itching Onset _____ Duration _____
☐Blisters Onset _____ Duration _____
☐Other _____ Onset _____ Duration _____
☐Rash Onset _____ Duration _____
☐Jaundice Onset _____ Duration _____

Describe the appearance of the rash _____
Did the case have multiple exposures? ☐Yes ☐No ☐Unknown
If yes, when _____
If yes, did symptoms recur? ☐Yes ☐No ☐Unknown
Other Symptoms _____

Please **FAX** completed forms to: Indiana State Department of Health (317) 234-2812.