

Exposure Event	Assessment	Notifier / Patient Details	PHU Review
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**Send notification to Medical Officer of Health at:**

**Exposure Event**

**Exposure route**     Ingestion     Inhalation     Skin contact     Eye contact     Unknown

**Date exposure began**     **OR** Month/Year  **OR** Unknown   

**Exposure length**     < 1 day     between 1 day & 1 month     ≥1 month     Unknown

**Place of exposure**     Home     Workplace     School/ECC  
 Public place     Unknown     Other

**Occupation**   

If you enter Occupation here it won't be written back to the PMS. If you wish to record in the PMS, update the Occupation field in the PMS and then Refresh the form.

**Intent**     Unintentional     Intentional     Unknown

**Is this case known to be linked to other cases of the same exposure event?**     Yes     No

**Substance**

**Substance categories**     Household chemical     Agrichemical     Industrial chemical  
 Fireworks/explosive     Lead     Unknown  
 Other

Examples:    Household: cosmetic, dishwashing powder    Industrial: solvent, chlorine, fumigant  
Agrichemical: pesticide, animal remedies, spraydrift    Other: mercury, arsenic

**Was exposure event spraydrift?**     Yes     No

**Lead absorption**

**Did you obtain a whole blood lead specimen for this lead exposure event?**  
 Yes     No

**Whole blood lead concentration - µmol/L**

**Source(s) of lead exposure**     Occupational     Non-occupational     Unknown

Lead based paint     Close contact with person whose occupation involves lead exposure  
 Pica     Indoor rifle range  
 Traditional medicine or cosmetic     Bullet/sinker manufacture  
 Other

**Enrolled in workplace lead monitoring**     Yes     No     Unknown

**Substance name (complete at least 1 field)**




	Chemical name	Product name	Common name	Unknown
e.g.	<i>sodium hypochlorite</i>	<i>Janola</i>	<i>bleach</i>	
<input checked="" type="checkbox"/>	<input style="width:250px;" type="text"/>	<input style="width:250px;" type="text"/>	<input style="width:250px;" type="text"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input style="width:250px;" type="text"/>	<input style="width:250px;" type="text"/>	<input style="width:250px;" type="text"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input style="width:250px;" type="text"/>	<input style="width:250px;" type="text"/>	<input style="width:250px;" type="text"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input style="width:250px;" type="text"/>	<input style="width:250px;" type="text"/>	<input style="width:250px;" type="text"/>	<input type="checkbox"/>

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Mandatory field

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<b>Systems affected</b> (tick all that apply)	<input type="checkbox"/> Central nervous system <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Musculoskeletal <input type="checkbox"/> Unknown	<input type="checkbox"/> Eye <input type="checkbox"/> Respiratory <input type="checkbox"/> Psychological <input type="checkbox"/> Other	<input type="checkbox"/> Skin <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Nil
<b>Symptoms / signs</b>	<input type="checkbox"/> Symptoms only <input type="checkbox"/> Unknown	<input type="checkbox"/> Signs with/without symptoms	<input type="checkbox"/> No signs or symptoms
<b>Are the symptoms/signs consistent with the substance?</b>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
<b>Lab tests requested</b>	<input type="radio"/> None requested <input type="radio"/> Pending <input type="radio"/> Confirmed		
<b>Referral</b>	<input type="radio"/> None <input type="radio"/> Emergency department <input type="radio"/> Outpatients <input type="radio"/> Other		
<b>Additional Information</b>			
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<b>Notifier Details</b>			
Name	<input type="text"/>	Assessment date	<input type="text"/> 
NZMC/NZNC	<input type="text"/>		
Role	<input type="text"/>	<b>Usual GP (if different to Notifier)</b>	
Practice	<input type="text"/>	Name	<input type="text"/>
Address	<input type="text"/>	 Practice	<input type="text"/>
	<input type="text"/>	NZMC	<input type="text"/>
	<input type="text"/>	Town/City	<input type="text"/>
Phone	<input type="text"/>	Phone	<input type="text"/>
<b>Case demography</b>			
Family Name	<input type="text"/>	Title	<input type="text"/>
First Name(s)	<input type="text"/>	Gender	<input type="radio"/> Male <input type="radio"/> Female
Date of Birth (dd/mm/yyyy)	<input type="text"/> 	NHI	<input type="text"/>
<b>Parent/Guardian</b>	<input type="text"/>		
	Required if person is younger than 16 years.		
Street Address	<input type="text"/>	Home phone	<input type="text"/>
Suburb	<input type="text"/>	Work phone	<input type="text"/>
Town/City	<input type="text"/>	Mobile phone	<input type="text"/>
Postcode	<input type="text"/>		
Ethnicity	<input type="text"/>	Occupation	<input type="text"/>
Ethnicity	<input type="text"/>		
Ethnicity	<input type="text"/>		
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<b>Public Health Unit responsible</b> <input type="text"/>			
<b>PHU action</b>			
<input type="checkbox"/> No further investigation <input type="checkbox"/> Investigation underway <input type="checkbox"/> Referred to another agency eg MBIE <input type="checkbox"/> Investigation complete			
<b>Reporting Source</b> <input type="text"/>			
<b>Case assignment</b>			
<input type="radio"/> Definite case <input type="radio"/> Probable case <input type="radio"/> Possible case <input type="radio"/> Not a case <input type="radio"/> Insufficient info to assign case status			
<b>Investigating Officer's name e.g. Health Protection Officer</b> <input type="text"/>			
<b>Clinician's name e.g. Medical Officer of Health</b> <input type="text"/>			
<b>Date of case review</b> <input type="text"/> 			
<b>Exposure event</b>			
<b>Specific name of place where exposure occurred eg Centre Port Wellington.</b> <input type="text"/>			
<b>Address where exposure occurred</b>		<b>Incident Address</b> 	
Street Address	<input type="text"/>	Street Address	<input type="text"/>
Suburb	<input type="text"/>	Suburb	<input type="text"/>
Town/City	<input type="text"/>	Town/City	<input type="text"/>
Postcode	<input type="text"/>	Postcode	<input type="text"/>
DHB	<input type="text"/>	DHB	<input type="text"/>
<b>What were the circumstances of the exposure? (tick as many as apply). The hazardous substance was being:</b>			
<input type="checkbox"/> manufactured <input type="checkbox"/> used to manufacture another product <input type="checkbox"/> transported <input type="checkbox"/> disposed of <input type="checkbox"/> stored <input type="checkbox"/> used, for its intended purpose <input type="checkbox"/> used, for a purpose outside of its usual use			
<b>Was exposure a result of non-compliance with one or more HSNO controls</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
<b>Notes</b> <input type="text"/>			
<b>Clinical course</b>			
<b>Approx time off work, school, normal duties as a result</b> <input type="radio"/> zero <input type="radio"/> 1-3 <input type="radio"/> 4-9 <input type="radio"/> 10+ days <input type="radio"/> Unknown			
<b>Was person hospitalised</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
<b>Name of Hospital</b> <input type="text"/>			
<b>Date admitted</b> <input type="text"/> 		<b>Date discharged</b> <input type="text"/> 	
<b>Died</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		<b>Date</b> <input type="text"/> 	
<b>Was hazardous substance injury or disease primary cause of death</b> <input type="radio"/> Yes <input type="radio"/> No			
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