

Cadmium

Agency: _____

Investigator: _____

Phone number: _____

STATE ONLY

Status: Confirmed Probable
 Suspect Not a case
 Exposure
 Reviewer initials: _____
 Referred to another state: _____

CASE

Last name: _____
 First and middle name: _____
 Maiden name: _____ Suffix: _____
 Address line: _____
 Zip: _____ City: _____
 State: _____ County: _____
 Phone: ()- - Type: _____
 Long-term care resident: Yes No Unknown
 Facility name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____
 Gender: Female Male Other _____
 Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____
 Marital status: Single Married Divorced Parent with partner Separated Widowed
 Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian
 Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown
 Parent/Guardian name: _____
 Parent/Guardian phone: ()- - Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____
 Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown
 Outbreak related: Yes No Unknown
 Outbreak name: _____
 Exposure setting: _____
 Epi-linked: Yes No Unk To whom: _____
 Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown
 State: _____ Country: _____

Healthcare provider information

Last name: _____
 First name: _____
 Provider title: ARNP MD DO NP PA
 Facility name: _____
 Address line 1: _____
 Address line 2: _____
 Zip code: _____ City: _____
 State: _____ County: _____
 Phone : ()- - Type: _____

LABORATORY FINDINGS

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____
 Date received: ____ / ____ / ____ Specimen source: Blood Urine Result type: Preliminary Final
 Test Type: _____ Test Result: _____
 Percent: _____ Result date: ____ / ____ / ____ Result: High Out of Range
 Low See Notes

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____
 Date received: ____ / ____ / ____ Specimen source: Blood Urine Result type: Preliminary Final
 Test Type: _____ Test Result: _____
 Percent: _____ Result date: ____ / ____ / ____ Result: High Out of Range
 Low See Notes

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____
 Date received: ____ / ____ / ____ Specimen source: Blood Urine Result type: Preliminary Final
 Test Type: _____ Test Result: _____
 Percent: _____ Result date: ____ / ____ / ____ Result: High Out of Range
 Low See Notes

OCCUPATIONS

Is the case employed, enrolled in school, or attending a child care facility? Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

(Complete the following sections for each known occupation)

Occupation #1: Job title: Facility name: Address: City: State: County: Phone: Type: Handle food: Attend or provide child care: Attend school: Work in a lab setting: Work in a health care setting: Direct patient care duties in lab or health care setting: Health care worker type:

Occupation #2: Job title: Facility name: Address: City: State: County: Phone: Type: Handle food: Attend or provide child care: Attend school: Work in a lab setting: Work in a health care setting: Direct patient care duties in lab or health care setting: Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: Isolated at entry: Isolation type (entry): Admission date: Discharge date: Days hospitalized: Currently isolated: Current isolation type:

CLINICAL INFO & DIAGNOSIS

Reporting source: Laboratory Physician Poison Control Self diagnosis

List any pre-existing medical conditions:

Symptoms: Abdominal pain or cramps, Anemia, Anosmia, Chest pain, Chills, Choking, Coma, COPD, Cough, Cyanosis, Diarrhea, Dizziness, Dry throat, Fever, Gout, Headache, Hypertension, Hypophosphatemia, Increased saliva production, Kidney Damage or renal failure, Kidney stones, Leg pain, Liver Damage, Lung Cancer, Lung Inflammation, Muscle aches, Muscle weakness, Nausea, Osteomalacia, Prostatic cancer, Proteinuria, Pulmonary edema, Rectal spasms, Shortness of breath, Sore throat or throat irritation, Sweet or metallic taste, Tachycardia, Tooth discoloration, Tracheo-bronchitis, pneumonia, Vomiting, Weakness, Weight loss, Wheezing, Other:

Health Impact: Fatal Non-fatal Was educational information provided? Yes No Unknown What was the time missed from work/school or daily activities? Current smoker? Yes No Unknown If no, did you smoke in the past? Yes No Unknown If yes, date quit: What resources were used by the patient? None known Treated on site Work clinic or nurse 911 Call Poison Control Call ED Only Visit to Physician/med provider Hospitalization

Does the case have a drinking water exposure? Yes No Unknown

For each drinking water exposure, complete a drinking water exposure table. Attach additional information if necessary.

Drinking water exposure #1	Location <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Farm, ranch, acreage <input type="checkbox"/> Orchard or Garden <input type="checkbox"/> Community Building <input type="checkbox"/> Community Outdoor Site or Recreation Area <input type="checkbox"/> Travel out of area <input type="checkbox"/> Commercial Building <input type="checkbox"/> Unknown	Drinking water source <input type="checkbox"/> Municipal <input type="checkbox"/> Rural water <input type="checkbox"/> Private well <input type="checkbox"/> Bottled						
		If well water, what was the date of last microbiologic and/or nitrate testing? _____						
		If municipal, rural, or bottled, what is the name of the provider? _____						
		Have there been any recent changes to the: <table style="float: right;"> <tr> <td>Taste of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Odor of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Color of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> </table>	Taste of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Odor of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Color of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Taste of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
Odor of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
Color of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							

Drinking water exposure #2	Location <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Farm, ranch, acreage <input type="checkbox"/> Orchard or Garden <input type="checkbox"/> Community Building <input type="checkbox"/> Community Outdoor Site or Recreation Area <input type="checkbox"/> Travel out of area <input type="checkbox"/> Commercial Building <input type="checkbox"/> Unknown	Drinking water source <input type="checkbox"/> Municipal <input type="checkbox"/> Rural water <input type="checkbox"/> Private well <input type="checkbox"/> Bottled						
		If well water, what was the date of last microbiologic and/or nitrate testing? _____						
		If municipal, rural, or bottled, what is the name of the provider? _____						
		Have there been any recent changes to the: <table style="float: right;"> <tr> <td>Taste of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Odor of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Color of the water?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</td> </tr> </table>	Taste of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Odor of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Color of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Taste of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
Odor of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
Color of the water?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							

Fish Consumption	Did the case eat fish, shellfish or seafood in the past two weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
	If yes, how much fish did the case eat? <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Less than one serving per week</td> <td><input type="checkbox"/> 4-6 servings per week</td> </tr> <tr> <td><input type="checkbox"/> 1 to 3 servings per week</td> <td><input type="checkbox"/> 7 or more servings per week</td> </tr> </table>	<input type="checkbox"/> Less than one serving per week	<input type="checkbox"/> 4-6 servings per week	<input type="checkbox"/> 1 to 3 servings per week	<input type="checkbox"/> 7 or more servings per week	
	<input type="checkbox"/> Less than one serving per week	<input type="checkbox"/> 4-6 servings per week				
<input type="checkbox"/> 1 to 3 servings per week	<input type="checkbox"/> 7 or more servings per week					
Where did the fish come from? <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Caught by self, family, friend</td> <td><input type="checkbox"/> Community Gathering</td> </tr> <tr> <td><input type="checkbox"/> Store bought</td> <td><input type="checkbox"/> Work</td> </tr> <tr> <td><input type="checkbox"/> School</td> <td><input type="checkbox"/> Restaurant</td> </tr> </table>	<input type="checkbox"/> Caught by self, family, friend	<input type="checkbox"/> Community Gathering	<input type="checkbox"/> Store bought	<input type="checkbox"/> Work	<input type="checkbox"/> School	<input type="checkbox"/> Restaurant
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<input type="checkbox"/> Store bought	<input type="checkbox"/> Work					
<input type="checkbox"/> School	<input type="checkbox"/> Restaurant					

In the last two weeks has the case taken:

Over the counter medicines? Yes No Unknown If yes, list: _____

Prescription medicines? Yes No Unknown If yes, list: _____

Nutritional supplements? Yes No Unknown If yes, list: _____

Herbal supplements? Yes No Unknown If yes, list: _____

Homeopathic medicines? Yes No Unknown If yes, list: _____

Illicit drugs? Yes No Unknown If yes, list: _____

FOR FINAL DETERMINATION ONLY:

Based on this investigation what was the primary determination for the source of the exposure?

<input type="checkbox"/> Alloys, including copper <input type="checkbox"/> Ammunition manufacturing <input type="checkbox"/> Auto mechanical work <input type="checkbox"/> Batteries <input type="checkbox"/> Bearing making <input type="checkbox"/> Cable and trolley wires <input type="checkbox"/> Cadmium vapor lamps <input type="checkbox"/> Ceramic and pottery making <input type="checkbox"/> Cigarette or tobacco smoke <input type="checkbox"/> Contaminated air, soil, dust, water, food or drink <input type="checkbox"/> Dental amalgam <input type="checkbox"/> Electrical equipment making <input type="checkbox"/> Electroplating	<input type="checkbox"/> Engraving <input type="checkbox"/> Fertilizers <input type="checkbox"/> Glass manufacturing <input type="checkbox"/> Hazardous waste sites <input type="checkbox"/> Incandescent lamp makers <input type="checkbox"/> Incinerators <input type="checkbox"/> Jewelry and costume jewelry <input type="checkbox"/> Jewelry making <input type="checkbox"/> Lithograph making <input type="checkbox"/> Lithophane makers <input type="checkbox"/> Liver or kidney meats consumption <input type="checkbox"/> Metal decorative items <input type="checkbox"/> Mining	<input type="checkbox"/> Mouthing objects (jewelry, toys) <input type="checkbox"/> Municipal solid waste recovery <input type="checkbox"/> Mushroom consumption <input type="checkbox"/> Paint - spraying, manufacturing, industrial <input type="checkbox"/> Pesticides <input type="checkbox"/> Pharmaceutical manufacturing <input type="checkbox"/> Photoelectric cell making <input type="checkbox"/> Pigment making <input type="checkbox"/> Plastic products making <input type="checkbox"/> Sewage sludge <input type="checkbox"/> Smelter <input type="checkbox"/> Solder <input type="checkbox"/> Textile printing <input type="checkbox"/> Welding
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Secondary source, if applicable: Choose from table above

Was the exposure associated with an incident or natural disaster? Yes No Unknown

ADDITIONAL LABORATORY INFORMATION

ADDITIONAL LAB #1

Test Name

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cadmium (Cd) Blood | <input type="checkbox"/> Cadmium (Cd) Occupational Monitor urine | <input type="checkbox"/> Cadmium (Cd) Concentration | <input type="checkbox"/> Heavy Metal Panel |
| <input type="checkbox"/> Cadmium (Cd) Urine (Spot/random) | <input type="checkbox"/> Cd/Cr ratio, Cadmium creatinine ratio | <input type="checkbox"/> Beta-2-microglobulin in urine (B2-M) | <input type="checkbox"/> Total Volume |
| <input type="checkbox"/> Cadmium (Cd) Urine (24 hr) | | <input type="checkbox"/> Creatinine (Cr or Crt) concentration | <input type="checkbox"/> Cadmium (Cd) urine |

Date reported to IDPH: / / Collection date: / / Collection time: _____

Numeric result: _____	Result unit:	<input type="checkbox"/> spot or random <input type="checkbox"/> ug/24 hr, mcg/24 hr, micrograms per 24 hours <input type="checkbox"/> mL or milliliters <input type="checkbox"/> hours <input type="checkbox"/> % or percent <input type="checkbox"/> 24 hr	Result: <input type="checkbox"/> Low (L) <input type="checkbox"/> High (H) <input type="checkbox"/> * <input type="checkbox"/> See comment
	<input type="checkbox"/> ug/L , mcg/L, micrograms per liter <input type="checkbox"/> mg/dL, milligrams per deciliter <input type="checkbox"/> ug/g Cr or mcg/g Cr, micrograms per gram <input type="checkbox"/> creatinine ratio <input type="checkbox"/> ug/d, mcg/d, micrograms per day		

LABORATORY COMMENTS:

ADDITIONAL LAB #2

Test Name

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Cadmium (Cd) Blood | <input type="checkbox"/> Cadmium (Cd) Occupational Monitor urine | <input type="checkbox"/> Cadmium (Cd) Concentration | <input type="checkbox"/> Heavy Metal Panel |
| <input type="checkbox"/> Cadmium (Cd) Urine (Spot/random) | <input type="checkbox"/> Cd/Cr ratio, Cadmium creatinine ratio | <input type="checkbox"/> Beta-2-microglobulin in urine (B2-M) | <input type="checkbox"/> Total Volume |
| <input type="checkbox"/> Cadmium (Cd) Urine (24 hr) | | <input type="checkbox"/> Creatinine (Cr or Crt) concentration | <input type="checkbox"/> Cadmium (Cd) urine |

Date reported to IDPH: / / Collection date: / / Collection time: _____

Numeric result: _____	Result unit:	<input type="checkbox"/> spot or random <input type="checkbox"/> ug/24 hr, mcg/24 hr, micrograms per 24 hours <input type="checkbox"/> mL or milliliters <input type="checkbox"/> hours <input type="checkbox"/> % or percent <input type="checkbox"/> 24 hr	Result: <input type="checkbox"/> Low (L) <input type="checkbox"/> High (H) <input type="checkbox"/> * <input type="checkbox"/> See comment
	<input type="checkbox"/> ug/L , mcg/L, micrograms per liter <input type="checkbox"/> mg/dL, milligrams per deciliter <input type="checkbox"/> ug/g Cr or mcg/g Cr, micrograms per gram <input type="checkbox"/> creatinine ratio <input type="checkbox"/> ug/d, mcg/d, micrograms per day		

LABORATORY COMMENTS:

NOTES:
