FAO POISONING INCIDENT FORM (Locust control)

Fill out this form for each (suspected) poisoning incident, and send it to the National Locust Unit in your country

1	**DATE & LOCATION OF POISONING INCIDENT**		
1-1	date of the incident:		
1-2	location of the incident (name; latitute/longitude):		
1-3	reference to Spray Monitoring Form (if relevant; page number):		
2	**INSECTICIDE DATA (of product involved in poisoning case)**		
2-1	trade name:	2-2	common name:
2-3	concentration (g a.i./l or %):	2-4	formulation type:
2-5	batch number:	2-6	production and/or expiry date:
2-7	solvent and mixing ratio (if relevant):		
3	**PERSONAL DETAILS (of suspected poisoned person)**		
3-1	name:		
3-2	sex: ☐ male ☐ female	3-3	age (years):
3-4	staff position (e.g. applicator, flag man, driver):		
4	**INCIDENT DETAILS**		
4-1	activity while exposed to insecticide (e.g. spraying, filling aircraft hopper, etc):		
4-2	personal protective equipment used (tick one or more boxes): ☐ boots ☐ hat ☐ apron ☐ coveralls ☐ face shield / goggles ☐ respirator ☐ gloves ☐ dust mask ☐ other (specify):		
4-3	way of exposure (tick one or more boxes): ☐ on skin ☐ by ingestion ☐ by inhalation		
4-4	estimate of quantity of exposure (e.g. spray cloud droplets, coveralls entirely drenched, drank 1-litre bottle, etc.):		
4-5	duration of exposure (hours until decontamination / treatment):		
4-6	other persons also exposed to insecticide: ☐ yes ☐ no		
4-7	other relevant details about the incident (describe):		
5	**SIGNS AND SYMPTOMS**		
5-1	observed signs and symptoms of poisoning (tick one or more boxes): ☐ skin irritation / rashes ☐ tingling or numbness of face or hands ☐ abdominal pain (stomach, belly) ☐ sweating ☐ headache ☐ nausea, vomiting ☐ tearing of eye(s) ☐ confusion, disorientation, incoordination ☐ diarrhea ☐ double vision ☐ muscle twitching, tremor ☐ respiratory failure, coma ☐ contraction of pupils ☐ runny nose ☐ seizures, convulsions ☐ salivation ☐ abnormal breathing ☐ death		
5-2	first onset of symptoms (hours or days after last exposure):		
5-3	cholinesterase measurement carried out: ☐ yes ☐ no		
5-4	type of cholinesterase measurement carried out (tick one box): ☐ plasma ☐ red blood cells ☐ whole blood		
6	**TREATMENT**		
6-1	treatment given: ☐ yes ☐ no		
6-2	type of treatment or antidote given (provide details):		
6-3	person taken to hospital or medical post: ☐ yes ☐ no		
6-4	period that person will be taken off insecticide application (days):		
7	**REPORTING**		
7-1	name of person who filled out this form:		
7-2	staff category (tick one box): ☐ medical ☐ paramedical ☐ non medical (specify)		