



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)

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 Occupational (specify): _____

Swimming

Wading

Boating

Fishing

Tubing/skiing

Other (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) _____

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 _____

Signs and Symptoms (Onset is from time of first exposure, duration is from time of onset.)

Symptomatic Yes No Unknown

General

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

Head, Eye, Ear, Nose, Throat

Earache Onset _____ Duration _____ Nasal congestion Onset _____ Duration _____
Headache Onset _____ Duration _____ Sore throat Onset _____ Duration _____
Conjunctivitis Onset _____ Duration _____ Other _____ Onset _____ Duration _____

Respiratory

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

Cardiovascular

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

Gastrointestinal

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

Genitourinary

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

Musculoskeletal

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

Neurologic

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

Dermal

Itching Onset _____ Duration _____ Rash Onset _____ Duration _____
Blisters Onset _____ Duration _____ Jaundice Onset _____ Duration _____
Other _____ 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.