

HARMFUL ALGAL BLOOM (HAB) HUMAN ILLNESS REPORT

Illinois Department of Public Health
Communicable Disease Control Section
Phone: 217-782-2016 Fax: 217-524-0962



Reporting Entity:

☐ General Public ☐ Health Care Provider ☐ Poison Control Center ☐ Local Agency
☐ State Agency ☐ Other _____

Contact Name _____ Phone Number _____ home/work/cell

Identifying information for case:

Name _____ Phone Number _____ home/work/cell

Address _____ County _____

Demographic information for case:

Date of Birth ____/____/____ Height: ____' ____" Weight: ____lbs

Sex:

☐ Male ☐ Female

Ethnicity:

☐ Hispanic ☐ Non-Hispanic

Race:

☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Unknown ☐ Other _____

Suspected source of exposure:

☐ Public water body (name and location) _____

☐ Home/private water body (name and location) _____

☐ Food (type) _____

☐ Drinking water (source/location) _____ ☐ Other (describe) _____

If exposure source was a water body:

Visible algae present: ☐ Yes ☐ No ☐ Unknown Odor: ☐ Yes ☐ No ☐ Unknown

Describe water body color and appearance _____

Sick or dead animals present (type, number):

☐ Yes ☐ No ☐ Unknown _____

Activities during exposure to water body:

☐ Swimming ☐ Wading ☐ Boating ☐ Fishing ☐ Tubing/skiing ☐ Other _____

Exposure details

Suspected route(s) of exposure:

☐ Inhalation ☐ Drinking/Swallowing ☐ Skin contact ☐ Other _____

Date(s) of exposure:

_____/_____/_____ ____/____/_____ ____/____/_____

Total duration of exposure: _____minutes/hrs/days

Symptoms:Did case seek medical attention? ☐ Yes ☐ No

Onset Date of Symptoms ____/____/_____ Duration of Symptoms _____ days

General:

☐ Fever ☐ Headache ☐ Nasal Congestion ☐ Fatigue ☐ Eye redness/irritation
☐ Sore throat

Respiratory:

☐ Cough ☐ Wheezing ☐ Shortness of breath

Gastrointestinal:

☐ Nausea ☐ Vomiting ☐ Diarrhea

Muscular/skeletal:

☐ Muscle pain ☐ Joint pain ☐ Difficulty walking

Neurologic:

☐ Numbness ☐ Blurred vision ☐ Tingling/burning ☐ Confusion ☐ Paralysis
☐ Seizures ☐ Coma

Dermal:

☐ Rash ☐ Blisters ☐ Itching

Other symptoms (please describe)_____

Are you aware of other people that were exposed and became ill? ☐ Yes ☐ No*If yes:*

Name and contact information of exposed person(s)_____

Exposure/illness description_____

Please mail or fax completed form to the Illinois Department of Public Health Communicable Disease Control Section. Mailing address: 525 W Jefferson St., Springfield IL 62761. Fax: 217-524-0962