**NEW YORK STATE DEPARTMENT OF HEALTH COMMUNITY RECEPTION CENTER (CRC) FORM**

**SECTIONS WITH GRAY BACKGROUND SHOULD BE COMPLETED BY STAFF**

**DATE** __ / __ / __ **MILITARY TIME** __ __ __ __ **HRS** **LABORATORY INFORMATION**

- **HIGH PRIORITY?** □ YES □ NO
- **IF YES, WRITE "PRIORITY" ON SAMPLE CONTAINERS.**

**NAME:** _______________________________________

**ID:** _______________________________________

**LAB TRACKING CODE:** CRC01-|__|__|__|__|__|

**INSTRUCTIONS:** SECTION A SHOULD BE COMPLETED BY CRC RADIATION STAFF. SECTION A SHOULD ONLY BE COMPLETED FOR HIGHLY CONTAMINATED INDIVIDUALS OR THOSE WHO SET OFF THE PORTAL MONITOR. FOR INDIVIDUALS WHO DO NOT SET OFF THE PORTAL MONITOR, SKIP TO SECTION B.

**SECTION A. RADIATION CONTAMINATION SURVEY**

A1. POTENTIAL ROUTES OF CONTAMINATION

- HAS THE INDIVIDUAL SHOWERED OR CHANGED CLOTHES SINCE THE EVENT? □ YES □ NO □ UNK
- HAS THE INDIVIDUAL EATEN OR DRANK SINCE THE EVENT? □ YES □ NO □ UNK

**DESCRIBE (INCLUDE DATE/ TIME):** __________________________________________

- HAS THE INDIVIDUAL VOIDED URINE OR STOOL SINCE THE EVENT? □ YES □ NO □ UNK

A2. PRE-DECONTAMINATION MEASUREMENTS

- **TYPE OF DETECTOR:** ______________________________________________________
- **DETECTOR SERIAL #:** ______________________

**UNITS:** □ CPS □ CPM □ BQ □ CI

**USING LINES BELOW, RECORD MEASURED LEVELS OF CONTAMINATION FOR SPECIFIED BODY AREAS. SPECIFY ON THE DIAGRAM AND, WHERE LEVELS ARE RECORDED IF LEVELS REFERS TO LEFT OR RIGHT, FRONT OR BACK:**

- **FACE/NECK**
- **TRUNK**
- **UPPER EXTREMITY**
- **LOWER EXTREMITY**

**TYPE:** □ ALPHA □ BETA □ GAMMA

**RECORD LEVELS MEASURED AT THE HEAD/NECK AREA: |__|__|__|__|__|__|__|** **UNITS** □ CPS □ CPM □ BQ □ CI

A3. POST-DECONTAMINATION MEASUREMENTS (USE DIAGRAM TO INDICATE AREAS OF CONTAMINATION)

- **TYPE OF DETECTOR:** ______________________________________________________
- **DETECTOR SERIAL #:** ______________________

**UNITS:** □ CPS □ CPM □ BQ □ CI

**USING LINES BELOW, RECORD MEASURED LEVELS OF CONTAMINATION FOR SPECIFIED BODY AREAS. SPECIFY ON THE DIAGRAM AND, WHERE LEVELS ARE RECORDED IF LEVELS REFERS TO LEFT OR RIGHT, FRONT OR BACK:**

- **FACE/NECK**
- **TRUNK**
- **UPPER EXTREMITY**
- **LOWER EXTREMITY**

**TYPE:** □ ALPHA □ BETA □ GAMMA

A4. DOES INDIVIDUAL HAVE ANY POTENTIALLY CONTAMINATED OPEN WOUNDS OR RETAIN A RADIOACTIVE FOREIGN BODY? □ YES □ NO

**INSTRUCTIONS:** IF URINE SAMPLE IS COLLECTED, ENSURE THAT LAB PRIORITIZATION INFORMATION IS INCLUDED IN LABORATORY INFORMATION SECTION (UPPER RIGHT OF FRONT PAGE) BEFORE THE INDIVIDUAL IS MOVED TO THE REGISTRY ENROLLMENT AREA. REFER TO LAB PRIORITIZATION GUIDANCE FOR CRITERIA TO ASSIST IN IDENTIFYING HIGH PRIORITY SAMPLES.
SECTION B. REGISTRY CONTACT INFORMATION

B1. NAME

____________________________________________________________________________

B2. ADDRESS

STREET____________________________________________________________________________

CITY____________________________________ STATE __ __ ZIP__ __  __  __  __

B3. PHONE NUMBER: (__ __ __) __ __ __-__ __ __

B4. DATE OF BIRTH: ___ ___ / ___ ___ / ___ ___ ___ ___

M M D D Y Y Y Y

B5. GENDER

☑ MALE ☐ FEMALE ☐ REFUSE TO ANSWER

☐ YES ☐ NO ☐ REFUSE TO ANSWER

B6. ARE YOU PREGNANT?

SECTION C. EXPOSURE INFORMATION

C1. PLEASE INDICATE WHICH BEST DESCRIBES THE CAPACITY IN WHICH YOU MAY HAVE BEEN EXPOSED:

☐ FIRST RESPONDER (E.G. FIRE, LAW ENFORCEMENT, EMS)

☐ WORE PPE ☐ DID NOT WEAR PPE

☐ OTHER ON-SCENE RESPONDER

☐ LOCAL ☐ STATE ☐ FEDERAL ☐ OTHER (SPECIFY:__________________________)

☐ GENERAL PUBLIC

☐ OTHER (SPECIFY:_____________________________)

C2. DID YOU SEE OR HEAR THE EXPLOSION? ☐ YES ☐ NO

C3. WERE YOU INDOORS OR OUTDOORS AT THE TIME OF THE RELEASE? ☐ INDOORS ☐ OUTDOORS

C4. LOCATION/ADDRESS WERE YOU AT WHEN THE EVENT OCCURRED?

LOCATION____________________________________________________

STREET ______________________________________________________

CITY _____________________________ STATE __ __ ZIP__ __  __  __  __

C5. FOLLOWING THE EVENT, HOW LONG WERE YOU AT THE LOCATION OR ADDRESS LISTED ABOVE? ______ MINS / HRS (CIRCLE ONE)

SECTION D. CLINICAL INFORMATION

D1. SINCE THE INCIDENT, HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING SYMPTOMS:

<table>
<thead>
<tr>
<th>SYMPTOM</th>
<th>TIME OF ONSET (SINCE EXPOSURE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>REPEATED VOMITING</td>
<td>☐ &lt;10 MIN ☐ &lt;1 HR ☐ 1-2 HRS ☐ &gt;2 HRS ☐ NONE</td>
</tr>
<tr>
<td>DIARRHEA</td>
<td>☐ &lt;1 HR ☐ 1-3 HRS ☐ 3-8 HRS ☐ &gt; 8 HRS ☐ NONE</td>
</tr>
<tr>
<td>SEVERE HEADACHE</td>
<td>☐ 1-2 HR ☐ 3-4 HRS ☐ 4-24 HRS ☐ NONE</td>
</tr>
<tr>
<td>FEVER</td>
<td>☐ &lt;1 HR ☐ 1-2 HR ☐ 2-3 HRS ☐ NONE</td>
</tr>
<tr>
<td>CONFUSION</td>
<td>☐ YES, AT ANY TIME ☐ NONE</td>
</tr>
<tr>
<td>UNCONSCIOUSNESS</td>
<td>☐ YES, AT ANY TIME ☐ NONE</td>
</tr>
</tbody>
</table>

ADDITIONAL SYMPTOMS AND ONSET: ____________________________________________________________

D2. PAST MEDICAL HISTORY

HAVE YOU RECENTLY RECEIVED DIAGNOSTIC STUDIES INVOLVING NUCLEAR MEDICINE (E.G. STRESS TEST, THYROID EXAM)? ☐ YES ☐ NO ☐ UNK

IF YES, WHEN ____________________________

HAVE YOU RECENTLY RECEIVED CANCER TREATMENT (E.G. RADIATION THERAPY, BRACHYTHERAPY FOR PROSTATE OR THYROID CANCER)? ☐ YES ☐ NO ☐ UNKNOWN

IF YES, WHEN ____________________________

INSTRUCTIONS: REFER TO BIOASSAY CRITERIA GUIDANCE TO DETERMINE IF URINE SAMPLE SHOULD BE COLLECTED. IF URINE SAMPLE IS COLLECTED, ENSURE THAT LAB PRIORITIZATION INFORMATION IS INCLUDED IN LABORATORY INFORMATION SECTION (UPPER RIGHT OF FRONT PAGE). REFER TO LAB PRIORITIZATION GUIDANCE FOR CRITERIA TO ASSIST IN IDENTIFYING HIGH PRIORITY SAMPLES.