

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

SECTIONS WITH GRAY BACKGROUND SHOULD BE COMPLETED BY STAFF

DATE / / MILITARY TIME HRS
MO DAY YEAR

NAME: _____

ID: _____

LABORATORY INFORMATION

HIGH PRIORITY? YES NO

IF YES, WRITE "PRIORITY" ON SAMPLE CONTAINERS.

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

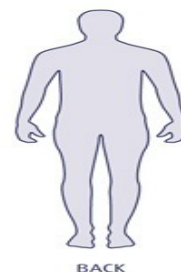
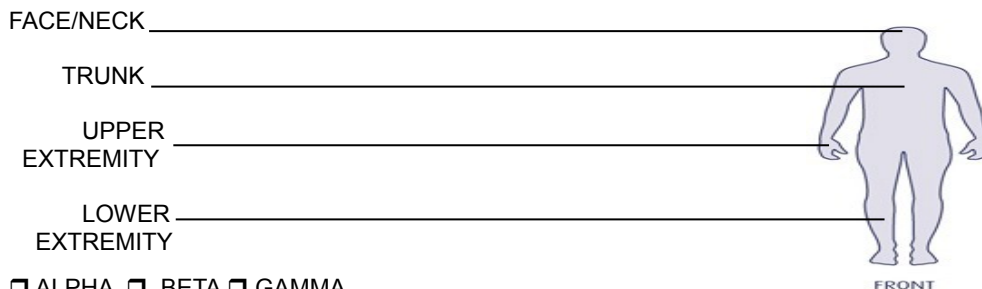
DESCRIBE (INCLUDE DATE/ TIME): _____
 HAS THE INDIVIDUAL VOIDED URINE OR STOOL SINCE THE EVENT? YES NO UNK

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:



TYPE: ALPHA BETA GAMMA

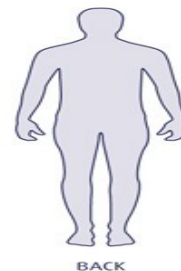
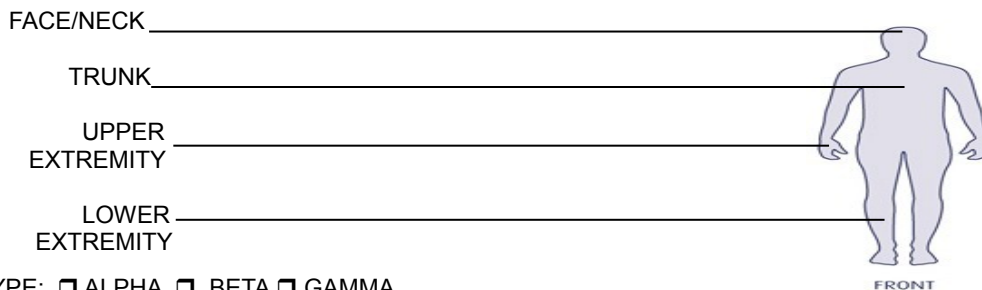
RECORD LEVELS MEASURED AT THE HEAD/NECK AREA: |_|_|_|_|_|_|_|_| UNITS CPS CPM BQ CI

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:



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.

INSTRUCTIONS: SECTIONS B,C,D SHOULD BE COMPLETED BY ALL INDIVIDUALS WHO ARE ASSESSED IN THE COMMUNITY RECEPTION CENTER.

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

B6. ARE YOU PREGNANT?

YES NO REFUSE TO ANSWER

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)

<p>FOR STAFF USE ONLY PROVIDE AN ESTIMATE OF THE DISTANCE BETWEEN LOCATION OR ADDRESS AND INCIDENT SITE</p> <p><input type="checkbox"/> ≤1 MILE <input type="checkbox"/> 1-5 MILES <input type="checkbox"/> 5-10 MILES <input type="checkbox"/> >10 MILES</p>
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SECTION D. CLINICAL INFORMATION

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

<u>SYMPTOM</u>	<u>TIME OF ONSET (SINCE EXPOSURE)</u>				
REPEATED VOMITING	<input type="checkbox"/> <10 MIN	<input type="checkbox"/> <1 HR	<input type="checkbox"/> 1-2 HRS	<input type="checkbox"/> >2 HRS	<input type="checkbox"/> NONE
DIARRHEA	<input type="checkbox"/> <1 HR	<input type="checkbox"/> 1-3 HRS	<input type="checkbox"/> 3-8 HRS	<input type="checkbox"/> > 8 HRS	<input type="checkbox"/> NONE
SEVERE HEADACHE	<input type="checkbox"/> 1-2 HR	<input type="checkbox"/> 3-4 HRS	<input type="checkbox"/> 4-24 HRS		<input type="checkbox"/> NONE
FEVER	<input type="checkbox"/> <1 HR	<input type="checkbox"/> 1-2 HR	<input type="checkbox"/> 2-3 HRS		<input type="checkbox"/> NONE
CONFUSION	<input type="checkbox"/> YES, AT ANY TIME		<input type="checkbox"/> NONE		
UNCONSCIOUSNESS	<input type="checkbox"/> YES, AT ANY TIME		<input type="checkbox"/> NONE		

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.