



HOSPITAL SULTAN ABDUL AZIZ SHAH
UNIVERSITI PUTRA MALAYSIA
Kod Dokumen: HSAAS/UKA/BR45

NOTIFICATION OF OCCUPATIONAL POISONING /DISEASE FORM

WEHU - D1
(JKKP 7)

Send to:

Pengarah Kesihatan Negeri

Jabatan Kesihatan Negeri _____

Part A - Detail of Notifier
(Regulation 7(2) Registered Medical Practitioner)

Name

Designation

Address of clinic/hospital

Contact no.

Part B - Affected person (If more than one person please list the name in Part

Name

Date of birth

 / /
DD MM YY

New IC/Passport no.

Nationality

Gender

 Male Femal

Occupation

Ethnic group

Name and address of organization

District

State

Location of Incident

Part C - Occupational Poisoning/Disease

Date of diagnosis

 / /
DD MM YY

Diagnosis/Provisional diagnosis

Part D

- What kind of work did the patient do which may be associated with the disease?
(Describe the work activities)
- What was the hazard or agent been exposed to the patient?
- How long had the patient been exposed to the hazard or agent?
- How long had the patient been experiencing the symptoms?

Signature of Notifier

Date

Name and address of attending doctor (Official Stamp)

1. Date of occurrence

/	/	
DD	MM	YY

2. Time

3. Place of occurrence

Home
 Workplace
 Others

4. Name(s) of poisoning agent(s)

Trade name _____

Active ingredient _____

5. Type of poisoning

Pesticide; Proceed to Question 6
 Chemical; Proceed to Question 7

6. If pesticide is the poisoning agent(s), please state type if known

(Tick more than one if mixture is used)

<input type="checkbox"/> Paraquat	<input type="checkbox"/> 2 - 4 - Dichlorophenoxyacetic Acid (2-4-D)
<input type="checkbox"/> Glyphosate	<input type="checkbox"/> Pyrethroid
<input type="checkbox"/> Organophosphate	<input type="checkbox"/> Warfarin
<input type="checkbox"/> Carbamate	<input type="checkbox"/> Superwarfarin
<input type="checkbox"/> Thiocarbamate	<input type="checkbox"/> Zinc phosphide
<input type="checkbox"/> Organochlorine	<input type="checkbox"/> Unknown
<input type="checkbox"/> Nitrophenol	<input type="checkbox"/> Others (please specify): _____

7. If chemical is the poisoning agent(s), please state type if known

(Tick more than one if mixture is used)

<input type="checkbox"/> Therapeutic drugs (pharmaceutical)	<input type="checkbox"/> Other industrial chemical
<input type="checkbox"/> Metals	<input type="checkbox"/> Household products (e.g. clorox)
<input type="checkbox"/> Gases	<input type="checkbox"/> Kerosene
<input type="checkbox"/> Agrochemical (excluding pesticide)	<input type="checkbox"/> Unknown
<input type="checkbox"/> Solvents	
<input type="checkbox"/> Others (please specify): _____	

8. Likely route(s) of poisoning:

(Tick more than one if mixed)

Oral
 Dermal Inhalation Mixed
 Others (please specify): _____

9. Circumstances of poisoning

Occupational
 Suicidal / Parasuicidal
 Homicidal
 Accidental

10. Was first aid given at the site of poisoning?

- Yes
- No

11. Is poisoning confirmed by laboratory investigation? Yes No

Others (please specify): _____

12. Outcome of poisoning

- Outpatient treatment
- Admitted to ward for ____ days
- Dead on arrival at hospital
- Died after ____ days treated in the ward Discharge at own risk (DAMA)
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