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Suicide prevention in Douglas County

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INTRODUCTION

Each year the American public spends billions of dollars on health research and health care. A multitude of volunteer organizations have been fostered to raise funds for support of research and care in specific diseases such as multiple sclerosis, heart disease, and mental retardation. The American public considers itself painfully aware of its prominent killers - heart disease and accidents - and cripplers - poliomyelitis and cerebral palsy. Most of these concerned Americans are unaware suicide ranks among the top ten killers in our nation - number four in the nineteen to forty-five year age group (1). Reputable studies indicate that attempted suicides exceed successful suicides by 8:1 (5). It is in the area of attempted suicide that prevention may play a decisive role.

In the past decade, the public has begun to stir restively in its complacent slumber, and an ever-increasing number of communities are becoming attuned to the needs of the acutely ill, suicidal members. A small skirmish has begun to open a war on this killer of twenty thousand citizens per year.

Where does Douglas County, Nebraska, stand in this skirmish? Approximately four hundred thousand people live in its confines; the Office of Biometry of the National Institute of Mental Health quotes 10.4/100,000 population as the current suicide rate in the United States, a rate suggesting that thirty to forty suicides per year could occur here (15). Recent

unpublished data collected in Douglas County suggests this is a valid figure. The number of attempted suicides may be near three hundred to three hundred fifty per year. In the scheme of preventive medicine, what has Douglas County done to aid those attempting suicide and what more can be done to rehabilitate these patients?

The purpose of this study was to investigate two aspects of Douglas County's assault on this killer: 1) the attitude of the medical community toward suicide prevention, and 2) the case disposition used by local physicians.

GENERAL PROBLEM

In considering the problem of suicide prevention, three questions arise;

1. Why prevent suicide?
2. Is suicide preventable?
3. How can it be prevented?

The first is a philosophical and ethical question of interfering with a person's "right" to do what he wants. Many volumes have been written by learned men to define "rights", "privileges", and the interference with same. Litman (7) provides a reasonable answer by pointing out that the suicidal person has mixed feelings about life and death; he wants to destroy his present image, but at the same time he wants to be rescued and reshaped into a new, more acceptable image. Society may undertake this reshaping for two reasons. To the Christian,

suicide is religiously forbidden and to society, the loss of a member is the loss of desirable productivity - hence the group's desire to rehabilitate.

In the fledgling field of suicide research, there is guarded optimism that suicide can be prevented. Litman and Farberow (7) suggest that the rationale for prevention is based on four considerations: crisis, ambivalence, communication, and action response. Suicide is a crisis occurring during a limited time; if the patient survives, he becomes re-adjusted and non-suicidal. The majority of patients have conflicting feelings about life and death; they may use the extreme of suicide to call attention to a desire for help to reshape and restore their lives. The patient is above all a person and, therefore, communicates by word and deed. The prevention of suicide then becomes a response to the first three conditions of crisis, ambivalence, and communication.

This provides a theoretical framework for prevention. The question of success rests on applicability to individual cases. On the basis of different methods of attempting suicide, one can attempt to identify the degree of ambivalence. The patient ingesting a sublethal dose of aspirin might be interpreted as more ambivalent than the patient who chews dynamite caps and, therefore, be considered a better candidate for help. This suggests that there is a finite population attempting suicide which can be helped but that the extent of the population is

unknown. Motto (9) and Cohen (2) have suggested a "case-finding" approach and have evolved an instrument to rate patients' suicidal potential to guide this preventive effort. It is called the Golden Gate Clinic Instrument and consists of fifteen questions answered "yes" or "no". From the number of "yes" answers, a classification of three parts ranging from low risk to suicide prone has been devised. By following a large series of cases, the probability of repeated suicidal behavior within eight years has been computed for each classification. This ranges from 1:22 in the low risk groups to 1:2 in the suicide prone group. With experience and such an instrument, the family physician could provide a case finding service designed to steer suicidal patients to appropriate therapy.

Only rudimentary data is available to support the contention that suicide can be prevented. Shneidman (13) reports categorically that the Los Angeles Suicide Prevention Center has demonstrated the ability to prevent suicide. Resnik (11) claimed minor reductions in the suicide rate in Dade County, Florida, during the initial year of operation of the FRIENDS of Dade County, an anti-suicide organization. He did not claim this organization was the responsible factor. Motto (8) was able to divide a series of cases into five basic categories according to their stability and reliability after therapy was begun. The categories ranged from a stable group which remained in therapy with a single agency to persons who frequently changed

therapists to those who disappeared. He felt those in the first category represented a true prevention potential. He reported in the same paper a one hundred fold increase in successful suicides among those with a previous attempt when compared to the general population.

Granting that suicide should be prevented and can be prevented, how is it prevented? It is probably fair to say that no other single problem requires more of a community's resources. The Los Angeles Suicide Prevention Center has the best documented experience with the community approach. To prevent suicide they use the total community - family, friends, clergy, physicians, psychologists, general hospitals, psychiatric hospitals, and volunteer groups. Litman (5) lists the Suicide Prevention Center's activities as identifying pre-suicidal individuals, evaluating suicidal danger, making recommendations and referrals, consulting with agencies and practitioners, and collecting data for increasing understanding of suicide and its prevention. As similar community approaches have developed throughout the country, modifications have been made to meet local needs and resources, but the basic approach remains the same.

After referral, intervention techniques such as family consultation, psychotherapy, and consultation with clergymen are employed. Case follow-up becomes highly important in those patients referred. This is supported by the incidence

of repeated suicidal behavior cited previously. These patients fall in the moderate to suicide prone group with probabilities of 1:8 to 1:2 of repeated behavior. Follow-up is the province of the family physician.

The approach to suicide that prededed the group approach and still prevails in most parts of our country is the individual worker. This involves the single physician more than any other person. The questions to be surveyed in this paper are the physician's image of his own adequacy in treating pre-suicidal patients and a review of the methods used in Douglas County. The ultimate question is whether or not we need a suicide prevention center.

METHOD

To limit the scope of this study, it was prepared in two parts. The first part consisted of a nine item questionaire sent to the members of the Douglas County Medical Society (see appendix A). This questionnaire was designed as a general tool to reflect physician's experience and opinions regarding suicide prevention. The questions were devised in co-operation with public health officials and psychiatrists with the aim to provide basic information regarding the physician's attitude toward involvement of public health in suicide prevention as well as his attitude toward and methods for treating potentially suicidal patients. Questions were based on the techniques of intervention previously outlined and on specific complaints

frequently voiced by physicians such as difficulty in identification, difficulty in referral, and need for more facilities.

The questionnaire was mailed with a brief letter of explanation (see appendix B) to the five hundred thirty-seven members of the Douglas County Medical Society. No attempt was made to select out physicians according to specialty or type of practice. The result was the inclusion of persons in private practice, research, teaching, and health. The answers were submitted to statistical analysis to establish important trends of thought in the medical community.

The second part consisted of a review of twenty-five cases of attempted suicide reported in Douglas County. The reviews were prepared from available hospital records. The majority of the cases were collected from the outpatient records of the Immanual Hospital and one case was reported from my personal experience at the University of Nebraska Hospital. Those cases from the Immanual Hospital accounted for twenty-four cases with twenty-three obtained from the records of the poison control center.

At the poison control center, a standardized form is prepared for each patient seen (see appendix C). A copy is kept by the department and a carbon is forwarded to the public health department of the county for follow-up. These records were reviewed for the period January 1, 1966, to December 25, 1966. The disposition of the twenty-three patients who had attempted

suicide was recorded and attempts made to pursue the hospital record of all who were admitted. These records were reviewed to establish which of the following measures had been taken:

a. Family counseling.

b. Psychiatric consultation.

c. Visit by clergyman.

d. Recommendation for Psychiatric aid after discharge.

e. Discharge diagnosis.

These criteria were chosen because they represent the general categories of approach utilized by the Los Angeles Suicide Prevention Center in their efforts to prevent suicide.

The remaining two cases were reviewed in the same manner although they did not come from poison control records.

RESULTS

PHYSICIAN QUESTIONNAIRE. Returns were received from two hundred eighty-eight physicians representing a 53.6% response. Of those answering, 60.2% indicated they had been called upon to deal with suicidal patients. This figure excludes pathologists who indicated only post mortem involvement.

The second question applied only to those physicians who had treated suicidal patients. Of this group, one hundred forty-five(83.9%) had employed a psychiatrist in consultation. It is impossible to determine how many psychiatrists answered this question. A similar number, one hundred forty-nine, had hospitalized their patients. Forty physicians (23.1%) had

attempted treatment on an outpatient basis while fifty-eight (33.5%) had utilized combination therapy. Family consultation was utilized by twenty-four (13.9%) while physicians other than psychiatrists were called by ten physicians (5.8%).

Two questions considered the adequacy of facilities in Douglas County and the need for improvements. One hundred fifteen persons (46.4%) indicated they felt the facilities were adequate, and fifty-eight (20.1%) felt they were inadequate. Ninety (31.2%) felt there were gaps to be closed and fifty-two (18%) stated there were no such gaps.

Difficulty identifying potentially suicidal patients was reported by one hundred thirty-four physicians (46.5%) and denied by seventy (24.2%).

The hypothetical question of how to approach suicide was answered as follows by two hundred thirteen physicians:

Hospitalization	97 (45.6%)
Outpatient	5 (2.3%)
Combination	44 (20.6%)
Family Consultation	29 (13.6%)
Referral to clergy	21 (9.9%)
Referral to another physician	9 (4.2%)
Referral to psychiatrist	172 (81%)

One hundred fifty three (53.1%) of those responding indicated no difficulty with response of the patient's family when psychiatric referral was recommended but forty-nine (17%)

experienced such difficulty.

When asked which of four possible services would best assist them in practice, physicians responded as follows:

Post-graduate course	59 (20.4%)
Emergency referral facility	72 (25%)
Routine referral facility	32 (11.1%)
Psychiatrist in each hospital	59 (20.4%)

One hundred forty-nine physicians (51.8%) felt suicide was a public health responsibility and ninety-one (31.6%) answered "no". Forty-eight (16.6%) did not answer the question.

All percentages except where indicated were calculated on the total number of physicians returning questionaires.

CASE REVIEWS. Table one summarizes the data available on the poison control records of the twenty-three patients reviewed at the Immanual Hospital.

The hospital records were obtained for eleven of the thirteen hospitalized patients. Table two presents the data obtained from the hospital records. One patient signed out of the hospital against medical advice but with a recommendation to seek psychiatric aid. Three of the five patients seen by psychiatrists were transferred to a psychiatric hospital for inpatient care. One patient was transferred to another general hospital for medical therapy and was lost to follow-up. Only one of the hospitalized patients had been under psychiatric care at the time of the attempt. The one patient who attempted

Male	6
Female	17
Average age: Male	22 years
Female	25.8 years
Admitted	13
Outpatient	7
Transferred	5
Previous treatment	2

TABLE 1

Data from poison control records.

Total patients	11
Family counseling	11
Psychiatric consultation	5
Visit by clergyman	2
Recommendation for psychiatric aid	2
Final diagnosis: Attempted suicide	0

TABLE 2

Data from hospital records.

suicide by shooting was treated medically and transferred to a psychiatric hospital. She had been seen frequently by both a psychiatrist and a clergyman prior to the transfer.

CASE SUMMARIES

CASE ONE. A twenty-four year old negro female was admitted to University Hospital on December 12, 1966. The family reported that she had been unresponsive for the preceding twenty-four hours. She had been brought to the family home the preceding afternoon by her estranged husband. She had been drinking and was noted to have a bruise over her left eye. She had been allowed to remain in bed apparently asleep but the family became alarmed when she did not awaken after nearly twenty-four hours.

On admission, the patient was having auditory and visual hallucinations. She did not respond to vocal stimuli but thrashed around wildly at the slightest touch. Physical exam revealed only a contusion of the left periorbital area. Skull x-rays and cervical spine films were normal.

The patient was hospitalized for observation, and a neurology consultation was obtained the following morning. The patient's condition was unchanged, and the consultant felt the condition represented drug ingestion or delerium tremens. She was sedated and on the third hospital day her sensorium had cleared.

It was subsequently learned that the patient had attempted suicide with forty Elavil tablets. This was the third attempt in eight months. On discharge, an appointment was arranged at the

suggestion of the attending physicians for the patient to be seen in the outpatient psychiatry clinic; the patient agreed but failed to keep the appointment.

CASE TWO. A forty year old white female was admitted to Immanual Hospital for treatment of self-inflicted gunshot wounds to the head. The patient was reportedly depressed over family discord. She was given medical treatment for the wounds, and immediately following her recovery she was seen by a psychiatrist and constant contact was maintained by the family minister.

The patient was blinded by the wound but suffered no other physical damage. Following adequate medical therapy, she was transferred to a local psychiatric hospital for extensive psychotherapy. She was being allowed to return home weekends at the time of this writing where the family was being used extensively to give support.

CASE THREE. A twenty year old negro female was seen in the Immanual Hospital emergency room following ingestion of thirty five grain aspirin tablets. She was hospitalized for observation because of her emotional lability. A psychiatrist saw the patient in consultation while she was hospitalized. She was subsequently transferred to Douglas County Hospital psychiatric ward and lost to follow-up.

COMMENT

The purpose of this paper was to evaluate the attitudes of doctors on suicide prevention and to establish what methods

are presently employed by physicians in meeting this problem. These points are important in determining where the community's efforts might best be directed to curb this growing problem.

In considering the data collected from the physician questionnaire, the sample represents one half the population under consideration. The question of this being a random sample could be effected by two factors. In the initial letter to physicians, it was indicated that the data would be used to complete a senior thesis for the University of Nebraska. This may have resulted in a disproportionate number of responses from physicians holding appointments to that faculty. The responses may also represent those interested in suicide prevention. Neither assumption can be verified and it is assumed that the responses are a random sample.

From the statistical data summarized in table three, one expected result may be inferred - most physicians would rely on psychiatric consultation. Eighty-three per cent indicated they had used such consultation, and 80% of those answering question six indicated they would use this service.

Another striking set of figures involved those persons who had utilized clergymen or who would do so. The figures were 13.9% and 9.9%, respectively. The latter figure represents a smaller total number because it was based on two hundred thirteen answers compared to two hundred eighty-eight for the former figure. This raises the question of utilizing the clergy to

Total returns		288
	YES	NO
Physician experience	173 (60.2%)	115 (39.7%)
Difficulty identifying	134 (46.5%)	70 (24.2%)
Familial resistance	49 (16%)	153 (53.1%)
General hospitals adequate	115 (39.8%)	58 (20.1%)
Need improvement	90 (31.2%)	52 (18%)
Public health responsibility	149 (51.8%)	91 (31.6%)

Facilities utilized by experienced physicians.

Hospitalization	149 (51.8%)	Clergymen	24 (13.9%)
Outpatient	40 (23.1%)	Other M.D.	10 (5.8%)
Combination	58 (33.5%)	Psychiatrist	145 (83.9%)
Family	41 (23.6%)		

Facilities the physician would use.

Hospitalization	97 (45.6%)	Clergymen	21 (9.9%)
Outpatient	5 (2.3%)	Other M.D.	9 (4.2%)
Combination	44 (20.6%)	Psychiatrist	172 (81%)
Family	29 (13.6%)		

Services to physicians.

Post-graduate education	59 (20.4%)
Emergency referral facility	72 (25%)
Routine referral facility	32 (11.1%)
Psychiatrist on call	59 (20.4%)

TABLE 3

Summary of data from questionnaire.

a greater extent in this problem. From these statistics, it would seem obvious that physicians do not call clergymen often, but the question remains, why? Is there a lack of communication? Is one group unwilling to work with the other? Are the patients unreceptive to help from the clergy? Probably, all three play a role in closing this avenue of help to the suicidal patient; it may not have been adequately explored in Douglas County. Further inquiry should be made to establish the validity of this source of aid. Such inquiry might take the lines of random interviewing of members of the medical and clerical communities to establish their relationships. Only experience could establish the patient's receptiveness.

The question of public health's role in suicide prevention brought interesting responses. A little over one half (51.8%) of those responding felt that public health had an important role. Nearly one third (31.6%) were against assigning a role to public health. The purpose of the question was to sound out the medical community on an active participation by the Douglas County Health Department. When the answers to this question were compared with those for number one, it was found that there was no statistical correlation between experience and belief regarding the role of public health. Of those giving a negative response to public health participation, several expressed fear that this represented further government encroachment on the medical community. These comments were in the minority

but may give a clue to the opposition expressed by others.

The figures for difficulty with identification in office visits and those for experience, questions one and five, were compared by the Chi square method. It was found that there was no statistical significance when comparing these figures. This suggests that those physicians with experience did not have any increased confidence in their ability to identify such patients. This is the anticipated result since most people who had responded had only limited numbers of such patients.

Questions three and four indicate only in a very general way that physicians are satisfied with the facilities for handling suicidal patients in the general hospitals of this community, but at the same time they feel improvements could be made. Such an attitude should be followed up to establish more concrete suggestions.

There was no clear cut majority opinion among those responding as to what would be of most benefit to the practicing physician. The central facility for emergency referral received the highest number of votes. The other three suggestions are presently available but may not be used to the fullest extent.

Much of the data supplied by physicians was confirmed in the small series of cases reviewed. Over half were hospitalized which is consistent with the stated policy of those answering the questionnaire. However, only five of the thirteen

hospitalized patients (38.4%) were seen by psychiatrist - well below the eighty to eighty-five per cent suggested by the questionnaire. This indicates that physicians may not make adequate use of such consultation. In considering the series of cases, it was apparent that the consultation was utilized in those cases considered to have been a serious threat to life. It was not used in cases where far from lethal doses of drugs were employed. This may represent a tendency for physicians to attach less importance to these attempts as serious signs of emotional illness. This tendency is challenged by the fact that those patients with previous attempts had utilized small doses of drugs on all occasions yet they were as emotionally unstable according to the psychiatric consultation notes as was the person using a gun. This same thought was borne out by the case summaries presented in this paper. These individuals nearly succeeded in what may have been a manipulative maneuver. They too had previously attempted suicide and gave lip service to the need for help.

An additional point brought out by the case reviews was that very few carried a discharge diagnosis of attempted suicide. This brings out a very difficult situation for anyone doing retrospective studies of suicide. This is by no means a new problem, but it is a point to be stressed in accurate record keeping - a must in modern medicine. This problem is even more common in the filing of death certificates.

The first case summary presented emphasizes two important points: 1) the suicidal patient may easily be misdiagnosed, and 2) guidance to proper therapy requires an aggressive approach by the attending physician. This patient had been hospitalized forty-eight hours before the thought of suicide occurred to the attending physicians. The family had been unwilling or unable to supply the important information of a previous suicide attempt. When the patient recovered, she openly discussed the attempts but in a smug, self-satisfied manner. On discharge, she was given an appointment to a psychiatric clinic but has not kept that appointment. This represents a lack of aggressiveness by all of us involved. She should have been seen for psychiatric evaluation before dischare, but this was foregone because of a need for hospital beds.

The second case represents a very carefully planned program for rehabilitation of a severely disturbed patient. All elements of the community were utilized and appear to be showing progress. Of course, caution must be used in predicting any success because this patient would be considered to have a 1:2 probability of repeated suicidal behavior in the next eight years if the Golden Gate Clinic Instrument were used. Her blindness adds a new factor to her depression.

Case number three represents a referral to psychiatric therapy due to extreme emotional lability in a person who might have been thought to be only manipulative in her attempts.

An alert clinician guided her to assistance before the attempt became fatal.

In conclusion, I think it is fair to say that I have been able to demonstrate that the modern physician has been trained to relie on the advice and resources of psychiatrists in the matter of suicide. It has also been demonstrated that the medical community feels that public health does have a role in the prevention of this killer. Such knowledge should open the way for expanded programs from this facility. It has not been possible to pinpoint what would most help the practicing physician, but a stronger emphasis on existing programs is needed. From the material assembled, I think five avenues for further work can be described:

1. Evaluation of physician-clergy relationships and the role of the clergy in suicide prevention.
2. Enumeration of the facilities available for suicide prevention in Douglas County.
3. Critique of the facilities available with special attention to the recommendations by physicians for improvement.
4. Follow-up studies of the patients treated through the Douglas County Hospital emergency room to further establish a pattern of practice.
5. Increased emphasis on post-graduate education in psychiatry.

SUMMARY

A nine point questionnaire was sent out to five hundred thirty-seven members of the Douglas County Medical Society to evaluate their experience and attitudes toward suicide and its prevention.

A series of twenty-five cases of attempted suicide were reviewed to establish a pattern of treatment for the suicidal patient. Emphasis was placed on the use of the total resources of the community for rehabilitation of the patient.

From the study, it became apparent that over half the physicians had been faced with treating suicidal patients. Over eighty had or would employ a psychiatrist in their therapy. The clergyman was found to play a minimal role in this area. Slightly more than half of the physicians felt that suicide was a responsibility of public health departments.

Further studies were proposed to improve the effectiveness of the existing facilities in providing for these patients. It was recommended that post-graduate education be emphasized to relieve the manpower shortage in the field of psychiatry.

APPENDIX A

QUESTIONNAIRE FOR PHYSICIANS

1. Have you been called upon to treat patients who have attempted suicide? YES.... NO.....
2. Check those facilities and services you employed in treatment of the suicide tendency.
    - ....a. Hospitalization.
    - ....b. Outpatient.
    - ....c. Combination hospital and outpatient.
    - ....d. Family consultation.
    - e. Referral to
        - ....1. Clergyman.
        - ....2. Physician other than psychiatrist.
        - ....3. Psychiatrist.
        - ....4. Other .....
3. Do you find facilities and services of general hospitals in Douglas County adequate to provide routine preventive care for potentially suicidal patients? YES.... NO.....
4. Are there gaps in the facilities and services which should be closed? YES.... NO.....
5. Do you find potentially suicidal patients difficult to identify in routine office visits? YES.... NO.....
6. What do you consider the most reasonable course of action when they are identified?
    - ....a. Hospitalization.
    - ....b. Outpatient.
    - ....c. Combination hospitalization and outpatient.
    - ....d. Family consultation.
    - e. Referral to
        - .... Clergyman.
        - .... Physician other than psychiatrist.
        - .... Psychiatrist.
        - .... Other .....
7. Do families strongly resist psychiatric referral? YES.... NO.....
8. Which of the following would be of greatest benefit to the practicing physician?
    - ....a. Postgraduate education in preventive psychiatry.
    - ....b. Central facility for EMERGENCY referral of patients.
    - ....c. Central facility for ROUTINE referral of patients.
    - ....d. Psychiatrists on call for each hospital.
    - ....e. Other .....
9. Do you consider suicide a concern or responsibility of public health? YES.... NO....

APPENDIX B

June 20, 1966

Dear Doctor

Because of the incidence of suicide, the medical profession is becoming increasingly aware of the needs for preventive measures in this field.

A limited study of suicide prevention in this country is now under way. As a part of this study, we would appreciate your completing the enclosed questionnaire.

Thank you for your cooperation.

Sincerely,
Gary D. Harris
Senior Student
University of Nebraska
College of Medicine

APPENDIX C

☆ U. S. GOVERNMENT PRINTING OFFICE: 1966-216-516

For clear copies please use ball point pen or sharp pencil

PART A - COMPLETE FOR ALL COPIES

NAME OF PATIENT *(last, first, middle)*

HOME ADDRESS *(street, city, county, state)*

NAME OF PARENT OR GUARDIAN

TRADE NAME | TYPE OF PRODUCT *(bleach, etc.)*

TOXIC CONSTITUENT *(arsenic, etc.)*

NAME AND ADDRESS OF MANUFACTURER

WHERE INFORMATION REGARDING INGESTED PRODUCT WAS OBTAINED

☐ Not available ☐ Books ☐ Label ☐ Manufacturer
☐ Cards ☐ Previous Knowledge ☐ Other _____

AGE Yrs. | Mos.

SEX ☐ M ☐ F

NO. G 39785

PHONE:

DATE INGESTED

TIME:

AMOUNT TAKEN *(estimated)*

SIGNS AND SYMPTOMS *(check one or more)*

☐ NONE
☐ Vomiting and/or nausea
☐ Vomiting and/or abd. pains
☐ Burns
☐ Fever over 101° F
☐ Convulsions
☐ Other _____
☐ Stupor
☐ Coma
☐ Hypotension
☐ Dyspnea
☐ Pneumonia
☐ Cyanosis

ACTION INVOLVED

☐ Accidental ingestion
☐ Suicidal intent
☐ Other _____

TYPE OF CASE

☐ Telephone inquiry (IF CHECKED COMPLETE PART B)
☐ Treated Case (IF CHECKED COMPLETE PART C)

ADVICE GIVEN, PERTINENT FINDINGS, & TREATMENT GIVEN:

PART B TELEPHONE

PERSON INQUIRING ☐ Medical ☐ Non-Medical

PART C - TREATED CASE

VOMITING	SUCCESSFUL YES	SUCCESSFUL NO
☐ Spontaneous		
☐ Induced		
☐ Ipecac Syrup		
☐ Other		
LAVAGE		

HOSPITALIZED ☐ NO ☐ YES

(If yes, specify number of days.) _____

HAS PATIENT BEEN PREVIOUSLY TREATED FOR POISONING?

☐ NO ☐ YES WHEN? _____

HEALTH DEPT. FOLLOW-UP DESIRED?

☐ YES
☐ NO

FATAL ☐ UNKNOWN ☐ NO
☐ YES, date of death:

REPORTING CONTROL CENTER'S NAME | SIGNATURE OF REPORTING OFFICIAL | DATE

PHS-2805 REV. 5-66 (Use Reverse Side For Remarks)

POISONING REPORT
SEND GREEN COPY TO:

Nat'l. Clearinghouse for Poison Control Centers, Div. of Accident Prevention, BSS
Public Health Service, Dept. of Health, Education, & Welfare,
Washington, D. C. 20201

Form Approved
Budget Bureau No. 68-R629.

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