iCAPS
INITIATIVE FOR COORDINATED ANTIDOTES PROCUREMENT IN SOUTH-EAST ASIA

Emergency request form

Instruction: To be completed by responsible physician or authorized person and sent to Ramathibodi Poison Center via designated national focal point and/or authorized channel(s).

1. Call your national focal point or authorized channel:

☐ Yes ☐ No

Date and time of call: ________________________

2. Call Ramathibodi Poison Center staff:

☐ Yes ☐ No

Date and time of call: ________________________

Requester

1. Name of person completing form: ________________________
2. Position: ________________________
3. Organization: ________________________
4. Organization address: ________________________
5. Telephone: ________________________
6. Mobile phone: ________________________
7. Email: ________________________

Physician contact information

1. Name of person completing form: ________________________
2. Position: ________________________
3. Organization: ________________________
4. Organization address: ________________________
5. Telephone: ________________________
6. Mobile phone: ________________________
7. Email: ________________________

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Patient information

Age: ______________________

Sex: ______________________

Nationality: ____

Exposure site: ____

Address of residence: _____________________________________

Exposure information

Name of exposure: ____

Exposure amount: ____

Route of exposure: ____

Type of exposure: ____

Date and time of exposure: ____

History:

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Initial Diagnosis:

1. Date of Evaluation and Diagnosis: ____

2. Treatment before request: ____

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Antidotes information

Number of antidotes needed: ________________________

1. **Medicine 1:**
   a. Name ____
   b. Quantity ____
2. **Medicine 2:**
   a. Name ____
   b. Quantity ____
3. **Medicine 3:**
   a. Name ____
   b. Quantity ____
4. **Date required (by when):** ____

Send the completed form to: contacticaps@gmail.com