



**Form B5 - Poisoning**

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| <i>Form of substance:</i>     | <input type="checkbox"/> Solid<br><input type="checkbox"/> Gas<br><input type="checkbox"/> Liquid<br><input type="checkbox"/> Unspecified  |
| <i>Type of substance:</i>     | <input type="checkbox"/> Household products, (please specify):<br><input type="checkbox"/> Prescription medicines, (please specify):<br><input type="checkbox"/> Non-prescription medicines, (please specify):<br><input type="checkbox"/> Not known |
| <i>Location of poisoning:</i> |  |