

Cryptosporidiosis

Orpheus ID

- confirmed
- presumptive
- suspect
- no case

Name _____
LAST, first, initials (a.k.a.)

COUNTY _____

Address _____
Street City Zip

Special housing _____

Phone number _____ / _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

ALTERNATIVE CONTACT

Name _____ Phone(s) _____
LAST, first, initials home (H), work (W), cell (C), message

DEMOGRAPHICS

DOB / /
m / d / y
 if DOB unknown, AGE _____
 Sex female male
 Language _____
 Country of birth _____
 Worksites/school/day care center _____
 Occupation/grade _____

RACE (*check all that apply*)
 white
 black
 Asian
 Pacific Islander
 American Indian/Alaska Native
 unknown
 other _____
 HISPANIC
 Yes No
 unknown declined

PROVIDERS, FACILITIES AND LABS

Reporter _____ Type (circle one)
 _____ name and phone number
 PMD Lab-fax
 MDx Lab-phone
 ER Lab-other
 ICP HCP
 Lab-ELR

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 _____ name and phone number
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Ok to contact patient (only list once)
 Local epi_name _____
 Date report received by LHD ____/____/____

BASIS OF DIAGNOSIS

CLINICAL DATA
 Symptomatic yes no unk
 if yes, ONSET on ____/____/____
 diagnosis date ____/____/____
 diarrhea yes no unk
 cramps yes no unk
 nausea yes no unk
 vomiting yes no unk
 loss of appetite yes no unk
 weight loss yes no unk
 fever highest temp _____
 Notes:

Deceased yes no date of death ____/____/____
 Cause: _____
 Hospitalized: yes no unk
 Name _____
 Chart number _____
 admit date ____/____/____ ICU
 discharge date ____/____/____
 Status: Check one:
 alive dead unknown transfer

Name _____
 Chart number _____
 admit date ____/____/____ ICU
 discharge date ____/____/____
 Status: Check one:
 alive dead unknown transfer

LABORATORY DATA
 Testing Lab _____
 Originating Lab _____
 Collection date ____/____/____
 Specimen tyoe:
 stool other _____
 Test Type pos neg
 Antigen
 DFA/IFA
 EIA
 Immunostat card
 O & P cysts trophs

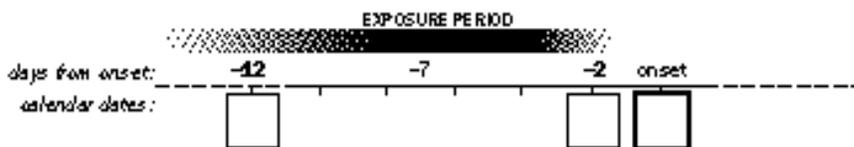
Treatment
 Drug name size/dose/frequency start date end date

Comments:



INFECTION TIMELINE

Enter onset date in heavy box. Count back to figure the probable exposure period. Ask about risk questions in this time period.



Most persons shed infectious oocysts in stool during the period of diarrhea. Shedding may continue in some patients for several days—possibly longer.

Interviewed yes no Interview date(s) _____ Interviewed by _____

Who patient provider parent other

Reason not interviewed (choose one)

- not indicated unable to reach out of jurisdiction deceased
- refused physician interview medical record review

RISKS Provide details as appropriate.

yes no refused unk

- travel outside home area (specify place, reason, transportation mode (car) travel companions
- visitor/refugee/immigrant from endemic area
- raw/unpasteurized milk
- unpasteurized apple juice/cider
- raw or uncooked shellfish
- other shellfish
- food at restaurants
- eating at other gatherings (potlucks, events)
- attends or works in daycare center/nursery
- contact with farm animals
- contact with pets sick with loose stools
- work with animal products, research, slaughter house, veterinary medicine
- contact with other people sick with diarrhea
- drinking untreated surface water
- other water-related
- recreational water (pools, water slides, lakes)

SOURCE OF HOME WATER

- private well water
- private surface water
- public/community system
name of company: _____
- bottled water
- unknown

OTHER FOLLOW-UP. Provide details as appropriate.

yes no refused unk

- does the case know anyone with a similar illnesses
- does case work or attend daycare
- is the case in diapers
- are other children/staff ill
- daycare/work restriction for case
- day care inspection as part of investigation
- follow up of household members
- water supply testing
- case educated about disease transmission

EPI-LINKAGE

- Associated with a known outbreak? yes no unk
- Close contact of another case yes no unk
- Specify nature of contact
 - co-worker daycare friend
 - household sexual
- Has the above case been reported? yes no unk
- If yes to any question, specify names, dates, places.*
- Outbreak ID _____

CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER

Name	DOB/Age	Sex	Relation to case	Occupation	Education provided	Last exposure	Onset date	Interview date	Sick
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> household <input type="checkbox"/> sexual	_____	_____	____/____/____	____/____/____	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> household <input type="checkbox"/> sexual	_____	_____	____/____/____	____/____/____	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> household <input type="checkbox"/> sexual	_____	_____	____/____/____	____/____/____	____/____/____	<input type="checkbox"/> Y <input type="checkbox"/> N

ADMINISTRATION

Remember to copy patient's name to the top of this page.

Completed by _____ Date _____ Phone _____

Case report sent to OHA on ____/____/____
Investigation sent to OHA on ____/____/____