

Cyclosporiasis

COUNTY

FOR STATE USE ONLY

____/____/____ case report

- confirmed
- presumptive
- suspect

____/____/____ interstate

Date investigation initiated: ____/____/____

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

e-mail address _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

- Lab Infection Control Practitioner
- Physician _____

Name _____

Phone _____ Date ____/____/____
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX
 female male

HISPANIC yes no unknown

RACE

- White American Indian
- Black Asian/Pacific Islander
- unknown refused to answer
- other _____

DATE OF BIRTH ____/____/____
m d y

or, if unknown, AGE _____

Worksites/school/day care center _____

Occupations/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic yes no unk
if yes, ONSET on ____/____/____
m d y

Check all that apply:

diarrhea yes no unk
if yes, ONSET on ____/____/____
m d y

Unusual fatigue pos neg unk

Weight loss pos neg unk
if yes, _____ lbs.

Hospitalized: yes no unk

name of hospital _____

date of admission ____/____/____
m d y

date of discharge ____/____/____
m d y

Transferred to/from another hospital:

yes no unk

Is the person immunocompromised?

yes no unk

HIV status: pos neg unk

Outcome: survived died unk

date of death ____/____/____
m d y

LABORATORY DATA

Lab confirmed yes no

if yes, Lab _____

Specimen:

- stool
- other _____

Specimen

collected ____/____/____
m d y

Confirmed at PHL:

yes no unk

EPI-LINKAGE

During the exposure period, was the patient...

associated with a known outbreak? yes no unk

a close contact of a **confirmed** or **presumptive** case? yes no unk

Has the above case been reported? yes not yet

Specify nature of contact:

household _____

if yes to any question, specify relevant names, dates, places, etc:

Does the case know about anyone else with a similar illness? yes no could not be interviewed

if yes, give names, onset dates, contact information, and other details.



PATIENT'S NAME ▶

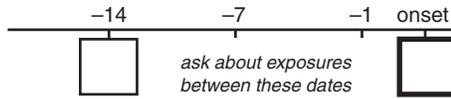
[Empty box for patient name]

INFECTION TIMELINE

Enter onset date in heavy box.
Count backwards to figure probable exposure period.

EXPOSURE PERIOD

days from onset:
calendar dates:



POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Skip this section if the case was already epi-linked.

- no risk factors could be identified
- patient could not be interviewed

POSSIBLE SOURCES:

- | | | |
|---|--------------------------|--------------------------|
| | yes | no |
| a | <input type="checkbox"/> | <input type="checkbox"/> |
| b | <input type="checkbox"/> | <input type="checkbox"/> |
| c | <input type="checkbox"/> | <input type="checkbox"/> |
| d | <input type="checkbox"/> | <input type="checkbox"/> |
- travel outside county to _____
 drinking untreated surface water
 recreational water (pools, water slides, lakes,...)
 raspberry, basil or lettuce consumption

- | | | | |
|---|--------------------------|--------------------------|---|
| e | <input type="checkbox"/> | <input type="checkbox"/> | other produce consumption |
| f | <input type="checkbox"/> | <input type="checkbox"/> | eating at restaurants |
| g | <input type="checkbox"/> | <input type="checkbox"/> | eating at other gatherings (potlucks, events) |
| h | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

SOURCE OF HOME WATER

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

Provide details about possible sources and risk factors

CONTACT MANAGEMENT AND FOLLOW-UP

OTHER FOLLOW-UP. Provide details as appropriate.

- hygiene education provided
- follow-up of other household member(s)
- testing of home/other water supply
- _____



ADMINISTRATION

Cyclosporiasis/December 2004

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

Completed by _____ Date _____ Phone _____ Case report sent to OHS on ___/___/___

Investigation sent to OHS on ___/___/___