FAX COMPLETED FORM TO 515-281-5698

Cholera

Agency:

Investigator: Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name:
First and middle name:
Maiden name:
Address line:
Zip: City:
State: County:
Phone: ( )- - Type:
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative ☐ Other
Organism: Type (e.g. serogroup):

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative ☐ Other
Organism: Type (e.g. serogroup):

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____

Date removed: / / Phone: ( )- - State: County: Type:

Handle food: ☐ Yes ☐ No ☐ Unknown

Attend or provide child care: ☐ Yes ☐ No ☐ Unknown

Attend school: ☐ Yes ☐ No ☐ Unknown

Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown

Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown

Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

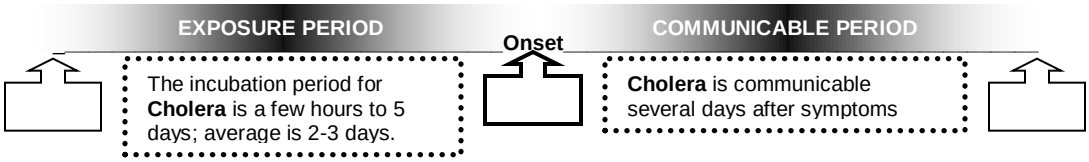
Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: / / Discharge date: / / Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



CLINICAL INFO & DIAGNOSIS

Symptoms

Diarrhea ☐ Yes ☐ No ☐ Unk

Nausea ☐ Yes ☐ No ☐ Unk

Vomiting ☐ Yes ☐ No ☐ Unk

Abdominal cramps ☐ Yes ☐ No ☐ Unk

Cellulitis ☐ Yes ☐ No ☐ Unk Site: _____

Sequelae ☐ Yes ☐ No ☐ Unk Type: _____

Shock ☐ Yes ☐ No ☐ Unk

Muscle Pain ☐ Yes ☐ No ☐ Unk

Visible bloody diarrhea ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Fever ☐ Yes ☐ No ☐ Unk _____ ☐ °F ☐ °C

Bullae Site: _____

Other Symptoms:

Symptoms ongoing: ☐ Yes ☐ No ☐ Unk

Date returned to normal activities: / /

Medical History

Has the patient had any of the following medical conditions?

Alcoholism ☐ Yes ☐ No ☐ Unk

Diabetes ☐ Yes ☐ No ☐ Unk

Gastric Surgery ☐ Yes ☐ No ☐ Unk

Heart Disease ☐ Yes ☐ No ☐ Unk

Heart Failure ☐ Yes ☐ No ☐ Unk

Kidney Disease ☐ Yes ☐ No ☐ Unk

Immunodeficiency ☐ Yes ☐ No ☐ Unk

Immunosuppressive Therapy ☐ Yes ☐ No ☐ Unk

Liver Disease ☐ Yes ☐ No ☐ Unk

Cancer ☐ Yes ☐ No ☐ Unk

Peptic Ulcer ☐ Yes ☐ No ☐ Unk

Other

In the 30 days prior to onset, were any of the following treatments received:

Antibiotics? ☐ Yes ☐ No ☐ Unknown *If Yes, complete the following table:*

Antibiotic:	Antibiotic:	Antibiotic:
Date started: / /	Date started: / /	Date started: / /
Dose:	Dose:	Dose:
# of days: # of times a day:	# of days: # of times a day:	# of days: # of times a day:
Route:	Route:	Route:

Chemotherapy: ☐ Yes ☐ No ☐ Unk Type: _____

Immuno-suppressant: ☐ Yes ☐ No ☐ Unk Type: _____

Radiation therapy: ☐ Yes ☐ No ☐ Unk Type: _____

Antacid or Ulcer Medication: ☐ Yes ☐ No ☐ Unk Type: _____

Systemic steroid: ☐ Yes ☐ No ☐ Unk Type: _____ Frequency: _____

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic:	Antibiotic:	Antibiotic:
Date started: / /	Date started: / /	Date started: / /
Dose:	Dose:	Dose:
# of days: # of times a day:	# of days: # of times a day:	# of days: # of times a day:
Route:	Route:	Route:

RISK FACTORS/TRAVEL

Vaccinated for cholera? ☐ Yes ☐ No ☐ Unknown **Number of vaccinations:** _____

Date vaccinated: / /	Date vaccinated: / /	Date vaccinated: / /
Lot #:	Lot #:	Lot #:
Vaccine type:	Vaccine type:	Vaccine type:
Manufacturer:	Manufacturer:	Manufacturer:

In the 7 days prior to the onset of the symptoms has the case:

Travel within U.S.? ☐ Yes ☐ No ☐ Unk State: _____ City: _____ Departure Date: / / Return Date: / /

Travel outside U.S.? ☐ Yes ☐ No ☐ Unk Country: _____ Departure date: / / Return date: / /

Cholera Exposure

Was the case exposed to Cholera? ☐ Yes ☐ No ☐ Unknown

If patient traveled outside of the U.S., what was the reason for travel?

☐ To visit relatives/friends ☐ Tourism ☐ Medical/Disaster relief ☐ Other: _____

☐ Business ☐ Military ☐ Unknown

Food Exposures

Raw/partially cooked seafood consumed? ☐ Yes ☐ No ☐ Unk

Clams:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk
Mussels:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk
Oysters:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk
Scallops:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk
Other shellfish:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk
Shrimp:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk
Crawfish:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk
Lobster:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk
Crab:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk
Fish:	☐ Yes ☐ No ☐ Unk	Fully cooked?	☐ Yes ☐ No ☐ Unk

Date Consumed: / /

If yes, where was the seafood from?

☐ Grocery Store Store(s) name: _____ Brand name: _____

Address: _____ City: _____ State: _____

☐ Restaurant Restaurant(s) name: _____

Address: _____ City: _____ State: _____

☐ Event/Gathering Event type: _____ City: _____ State: _____

Street vendor food consumed? ☐ Yes ☐ No ☐ Unk

If yes, was the food fully cooked? ☐ Yes ☐ No ☐ Unk

Vendor name: _____ Food(s) consumed: _____

Address: _____ City: _____ State: _____

Water Exposure

Went Swimming? ☐ Yes ☐ No ☐ Unk Water type: ☐ Fresh ☐ Salt ☐ Brackish ☐ Other, specify:_____

Location type (Ocean, lake, pool, etc.):

Location name: From date swam: / / To date swam: / /

Address: City: State:

Was the case's skin exposed to any of the following?

Drippings from raw or live seafood, including handling/cleaning: ☐ Yes ☐ No ☐ Unk

Marine life, including stings/bites: ☐ Yes ☐ No ☐ Unk

Date of most recent exposure: / /

If yes to any of the above exposures, was this an occupational exposure? ☐ Yes ☐ No ☐ Unk

If case's skin was exposed to any of the above, did the case sustain a wound or have a pre-existing wound?

☐ Yes, sustained a wound ☐ Yes, had a pre-existing wound ☐ Yes, uncertain if new or old wound ☐ No ☐ Unknown

If Yes, describe how wound occurred and site on body:

CONTACTS

Close contacts with the case and/or same exposures? ☐ Yes ☐ No ☐ Unknown

Close contacts of case or close contacts with same exposures

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

NOTES:

FAX COMPLETED FORM 515-281-5698