Cryptosporidiosis

Agency:
Investigator:
Phone number:

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

CASE

Last name: ______ Date of Birth: __/__/__ Estimated? ☐ Age: ______
First and middle name: ______ Gender: ☐ Female ☐ Male ☐ Other ___
Maiden name: ______ Suffix: ______ Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: __/__/__
Address line: ______ Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Zip: ______ City: ______ Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
State: ______ County: ______
Long-term care resident: ☐ Yes ☐ No ☐ Unknown Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Facility name: ______ Parent/Guardian name: ______
Facility phone: ( )- - Type: ______ Parent/Guardian phone: ( )- - Type: ______

EVENT

Diagnosis date: __/__/__ Onset date: __/__/__
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of death __/__/__
Event exception ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name: ______
Exposure setting: ______
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom______
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: ______ Country: ______

Healthcare provider information

Last name: ______
First name: ______
Title: ☐ ARNP ☐ MD ☐ PA ☐ DO ☐ NP
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
Organism: ***Cryptosporidium*** Type (e.g. serotype): ☐ *parvum* ☐ *hominis*

Laboratory: ______ Accession #: ______ Collection date: __/__/__
Date received: __/__/__ Specimen source: ______ Test type: ______
Result type: ☐ Preliminary ☐ Final Result date: __/__/__ Result: ☐ Positive ☐ Negative
Organism: ***Cryptosporidium*** Type (e.g. serotype): ☐ *parvum* ☐ *hominis*

Laboratory: ______ Accession #: ______ Collection date: __/__/__
______ Specimen source: ______ ______

Date received: __/__/__ Test type: ______

Result type: ☐ Preliminary ☐ Final Result date: __/__/__ Result: ☐ Positive ☐ Negative

Organism: ***Cryptosporidium*** Type (e.g. serotype): ☐ *parvum* ☐ *hominis*

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: ______ State: ______ County: ______
Date removed: __/__/__ Phone: ( )- - Ext: 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: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

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: ______ State: ______ County: ______
Date removed: __/__/__ Phone: ( )- - Ext: 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: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: ______ Admission date: __/__/__ Discharge date: __/__/__
Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): ______
Days hospitalized: ______
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Is case immunosuppressed? ☐ Yes ☐ No ☐ Unk

Symptoms:

☐ Diarrhea Onset date: __/__/__ Duration: hours/days
☐ Fever Onset date: __/__/__ Duration: hours/days
☐ Vomiting Onset date: __/__/__ Duration: hours/days
☐ Abdominal cramps Onset date: __/__/__ Duration: hours/days
☐ Other Onset date: __/__/__ Duration: hours/days
☐ Unexplained Weight loss Weight lost: lbs/Kg

TREATMENT

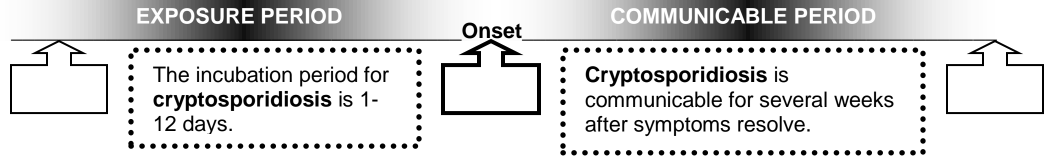
Medications prescribed? ☐ Yes ☐ No ☐ Unknown

Medication: ______ Medication: ______ Medication: ______
Date started: __/__/__ Date started: __/__/__ Date started: __/__/__
Dose: ______ Dose: ______ Dose: ______

Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
# of times a day: Route:	# of times a day: Route:	# of times a day: Route:

INFECTION TIMELINE

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



The incubation period for **cryptosporidiosis** is 1-12 days.

Cryptosporidiosis is communicable for several weeks after symptoms resolve.

RISK FACTORS/TRAVEL

Risk Factors/Travel Information – *In the 12 days prior to onset of symptoms did the case:*

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk City in Iowa: __________ Departure date: ___/___/___ Return date: ___/___/___

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk State: ______ City: __________ Departure date: ___/___/___ Return date: ___/___/___

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk Country: __________ Departure date: ___/___/___ Return date: ___/___/___

Visit restaurants? ☐ Yes ☐ No ☐ Unk *If Yes, complete the table below:*

Establishment name	Address/Zip	Date visited	Foods consumed	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Attended Group Gatherings (e.g. weddings)? ☐ Yes ☐ No ☐ Unk *If Yes, complete the following table:*

Type of gathering	Address/Zip	Date visited	Foods consumed	Foods prepared	Others ill?
		/ /			☐ Yes ☐ No ☐ Unk
		/ /			☐ Yes ☐ No ☐ Unk
		/ /			☐ Yes ☐ No ☐ Unk

Dietary Information – *In the 12 days prior to onset of symptoms did the case consume the following:*

Unpasturized milk:	☐ Yes ☐ No ☐ Unk	From dates consumed: / / / /	To dates consumed: / / / /
List all source/types:		List all brand names:	
Other unpasteurized milk products:	☐ Yes ☐ No ☐ Unk	From dates consumed: / / / /	To dates consumed: / / / /
List all source/types:		List all brand names:	
Other unpasteurized products (i.e. juice):	☐ Yes ☐ No ☐ Unk	From dates consumed: / / / /	To dates consumed: / / / /
List all source/types:		List all brand names:	

Animal Exposures – *In the 12 days prior to the onset of symptoms did the case have the following exposures:*

Visit or live on a farm:	☐ Yes ☐ No ☐ Unk	Contact with manure:	☐ Yes	☐ No	☐ Unk
		Contact with which animals on farm:	☐ Cows	☐ Sheep/goats	☐ Pigs
Visit any animal exhibits (petting zoo, county fair):	☐ Yes ☐ No ☐ Unk	Type of animals at exhibit:	☐ Cows	☐ Sheep/goats	☐ Pigs
Exhibit name:		Address/Zip/County:			

Water Exposures – *In the 12 days prior to the onset of symptoms did the case:*
Go swimming or have contact with recreational types of water? ☐ Yes ☐ No ☐ Unk *If Yes, complete the table below:*

Type		Location Type	Date visited	Facility name/ Street address & Zip
☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake	☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other__________	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	/ /	
☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake	☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other__________	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	/ /	

☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake	☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other________________	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	/ /	

Drinking water supply

Home:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**School:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well
Work:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**Child care:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well

Did patient use a water filter at home? ☐ Yes ☐ No ☐ Unk What type: ______________

Other Exposures – *In the 12 days prior to the onset of symptoms*

Wear diapers ☐ Yes ☐ No ☐ Unk **Have contact with diapers:** ☐ Yes ☐ No ☐ Unk

Have contact with immunocompromised person: ☐ Yes ☐ No ☐ Unk Setting: ☐ Home ☐ Work ☐ Other

Have sex with someone with similar symptoms: ☐ Yes ☐ No ☐ Unk Sexual preference: ☐ Hetero ☐ Homo ☐ Bisexual ☐ Unknown

Other risk factors

Do you have a child in child care? ☐ Yes ☐ No ☐ Unk List child care names: ______________________________

____

____

CONTACTS

Number of people living in case's household: _____

Are there close contacts of the case with same symptoms: ☐ Yes ☐ No ☐ Unknown

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

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

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

NOTES: