Giardiasis

CASE

Case Name

Last name: _____

First name: _____

Middle name: _____

Case Address

Address: _____

ZIP code: _____ City: _____

State: _____ County: _____

Long-term care resident: ☐ Yes ☐ No *If yes,* Facility name: _____

Case Demographic Information

Date of birth: / / Estimated? ☐

Country of birth: _____

Gender:
☐ Female ☐ Male ☐ Other

If female, pregnant?: ☐ Yes ☐ No ☐ Unknown

If pregnant, est. delivery date: / /

Case Demographic Information, continued

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with Partner ☐ Widowed

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unknown

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Case's Parent / Guardian

First name: _____ Last name: _____

Phone

Belongs to: ☐ Case ☐ Parent/Guardian

Phone 1: ( ) - Type: _____

Belongs to: ☐ Case ☐ Parent/Guardian

Phone 2: ( ) - Type: _____

EVENT

Event Onset

Diagnosis date: / / Onset date: / /

Event outcome:
☐ Survived this illness
☐ Died from this illness Date of death: / /
☐ Died unrelated to this illness
☐ Unknown

Refugee screening: ☐ Yes ☐ No Symptomatic: ☐ Yes ☐ No

Aware of diagnosis: ☐ Yes ☐ No

Speak English: ☐ Yes ☐ No If no, what lang: _____

Public Health (PH) Investigation Initiation

Date PH consulted healthcare provider: / /

Date PH first attempted to contact patient: / /

Was patient educated on disease prevention and control measures? ☐ Yes ☐ No

Laboratory Findings

Lab: _____

Collection date: / /

Test type: _____

Result: ☐ Positive ☐ Negative

Healthcare Provider

Last name: _____

First name: _____

Title: ☐ ARNP ☐ DO ☐ MD ☐ NP ☐ PA

Healthcare Provider Facility

Facility name: _____

Address: _____

ZIP code: _____ City: _____

State: _____ County: _____

Phone: ( ) - Ext: _____

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation' (e.g. attends school, nurse, retired)

Occupation

Occupation type: _____

Job title: _____

Occupation Dates

Worked after symptom onset: ☐ Yes ☐ No ☐ Unk

Removed from duties due to this illness: ☐ Yes ☐ No ☐ Unk

Date removed due to this illness: / /

Facility name: _____

Address line 1: _____

ZIP code: _____ City: _____ State: _____

County: _____

Phone: ( ) - Type: _____

In this occupation, does the Case:

Handle food: ☐ Yes ☐ No ☐ Unk

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

Attend or teach school: ☐ Yes ☐ No ☐ Unk

Work in a health care setting: ☐ Yes ☐ No

If Yes, health care worker type:

☐ Health Care Provider (e.g. Physician, nurse)
☐ Laboratory
☐ Environmental Services
☐ Other *specify*:

_____

If Yes, direct patient care duties? ☐ Yes ☐ No ☐ Unk

HOSPITALIZATIONS

Was the Case hospitalized due to this illness? ☐ Yes ☐ No ☐ Unknown

Still hospitalized at the time of this interview? ☐ Yes ☐ No ☐ Unknown

Hospital: _____

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

CLINICAL INFO & DIAGNOSIS

Symptoms:	Yes	No	Unk	*If yes,* complete :
Diarrhea	☐	☐	☐	Onset date: / / Duration: _____ ☐ Hours ☐ Days
Bloating	☐	☐	☐	
Malabsorption	☐	☐	☐	
Abdominal cramps	☐	☐	☐	
Unexplained Weight Loss	☐	☐	☐	Weight Lost: _____ lbs/Kg
Other: _____				
Symptoms ongoing at time of interview:	☐	☐	☐	
Date returned to normal activities:	/ /			

TREATMENT

Medications prescribed? ☐ Yes ☐ No ☐ Unk

If yes:

Medication: ☐ Albendazole ☐ Paromomycin ☐ Furazolidone ☐ Quinacrine ☐ Metronidazole ☐ Tinidazole ☐ Nitazoxanide ☐ Other _____ Date started: / /

Medication: ☐ Albendazole ☐ Paromomycin ☐ Furazolidone ☐ Quinacrine ☐ Metronidazole ☐ Tinidazole ☐ Nitazoxanide ☐ Other _____ Date started: / /

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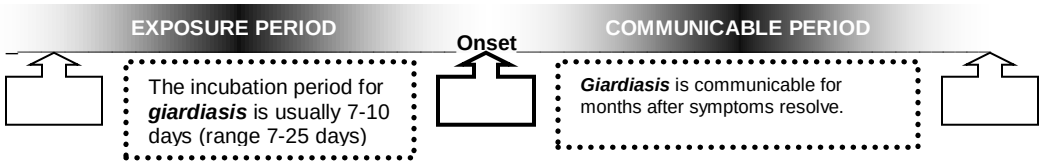
INFECTION TIMELINE

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



RISK FACTORS/TRAVEL

In the 25 days prior to onset of symptoms did the Case:

Travel within Iowa? ☐ Yes ☐ No ☐ Unk — City within Iowa: _____ — Departure date: / / — Return date: / /

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: / /

WATER EXPOSURES

In the 25 days prior to onset of symptoms did the Case drink well water?: ☐ Yes ☐ No

If Yes, where ?: ☐ *Home* ☐ *Work* ☐ *School* ☐ *Child care* ☐ *Other specify:* _____

In the 25 days prior to onset of symptoms did the Case drink from a stream or other untreated water source?: ☐ Yes ☐ No

If Yes, where?: _____

Did the Case go swimming, fishing, wading, etc. in the 25 days prior to onset of symptoms?: ☐ *Yes* ☐ *No*

If yes, complete the following:

Water Type	**Date Swam** *List date of each visit separately*	**Location name, Address, City, State, ZIP, County**
Chlorinated water *i.e. pool, spa*	Visit 1: ____/____/____	
	Visit 2: ____/____/____	
	Visit 3: ____/____/____	
	Add additional visits to the Notes section	
Unchlorinated water *i.e. river, lake, pond, unchlorinated kiddie pool*	Visit 1: ____/____/____	
	Visit 2: ____/____/____	
	Visit 3: ____/____/____	

ANIMAL EXPOSURES
In the 25 days prior to onset of symptoms, did the case:

Have farm animal or livestock contact: ☐ Yes ☐ No ☐ Unk Animals:

Have other animal contact in home: ☐ Yes ☐ No ☐ Unk Animals: Animal sick: ☐ Yes ☐ No ☐ Unk

RESTAURANT EXPOSURES
In the 25 days prior, did the case visit any restaurants? ☐ Yes ☐ No ☐ Unknown
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
		/ /		☐ Yes ☐ No ☐ Unk

OTHER EXPOSURES
In the 25 days prior to onset of symptoms did the Case have contact with human feces, such as diapering, caring for an incontinent person, or through sexual activity?

Wear diapers: ☐ Yes ☐ No ☐ Unk
Have contact with diapers: ☐ Yes ☐ No ☐ Unk
Care for an incontinent person: ☐ Yes ☐ No ☐ Unk
Through sexual activity: ☐ Yes ☐ No ☐ Unk
Sexual preference: ☐ Hetero ☐ Bisexual ☐ Homo ☐ Unknown

CONTACTS ***Reminder: Each contact must be entered as a new case in IDSS and interviewed.***

Are there contacts of the Case with similar symptoms? ☐ Yes ☐ No ☐ Unk

If yes, list contacts of the Case with similar symptoms:

First name: _____ Last name: _____
Symptom onset date: / /

Relationship to case:
☐ Family member (household)
☐ Family member (non-household)
☐ Roommate
☐ Sexual contact/ Significant other
☐ Friend/acquaintance
☐ Contact- work/school/etc.

Reminder: This contact must be entered as a new case in IDSS and interviewed.

First name: _____ Last name: _____
Symptom onset date: / /

Relationship to case:
☐ Family member (household)
☐ Family member (non-household)
☐ Roommate
☐ Sexual contact/ Significant other
☐ Friend/acquaintance
☐ Contact- work/school/etc.

Reminder: This contact must be entered as a new case in IDSS and interviewed.

NOTES: