



Cryptosporidiosis

County _____

Case name (last, first) _____

Birth date ___/___/___ Age at symptom onset _____ Years Months

Alternate name _____

Phone _____ Email _____

Address type Home Mailing Other Temporary Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____ LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification

Classification pending Confirmed Investigation in progress Not reportable Probable Ruled out Suspect

Investigation status

Complete Complete – not reportable to DOH Unable to complete Reason _____ In progress

Dates: **Investigation start** ___/___/___ Investigation complete ___/___/___ Record complete ___/___/___ **Case complete** ___/___/___

REPORT SOURCE

Initial report source _____ LHJ _____

Reporter organization _____

Reporter name _____ Reporter phone _____

All reporting sources (list all that apply) _____

DEMOGRAPHICS

Sex at birth: Female Male Other Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

Ethnicity Hispanic, Latino/a, Latinx Non-Hispanic, Latino/a, Latinx Patient declined to respond Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

Race Amer Ind/AK Native (**specify:** Amer Ind **and/or** AK Native) Asian Black or African American
 Native HI/Pacific Islander (**specify:** Native HI **and/or** Pacific Islander) White Patient declined to respond Unk

Additional race information:

Afghan Afro-Caribbean Arab Asian Indian Bamar/Burman/Burmese Bangladeshi Bhutanese

Central American Cham Chicano/a or Chicanx Chinese Congolese Cuban Dominican Egyptian

Eritrean Ethiopian Fijian Filipino First Nations Guamanian or Chamorro Hmong/Mong

Indigenous-Latino/a or Indigenous-Latinx Indonesian Iranian Iraqi Japanese Jordanian Karen

Kenyan Khmer/Cambodian Korean Kuwaiti Lao Lebanese Malaysian Marshallese Mestizo

Mexican/Mexican American Middle Eastern Mien Moroccan Nepalese North African Oromo

Pakistani Puerto Rican Romanian/Rumanian Russian Samoan Saudi Arabian Somali

South African South American Syrian Taiwanese Thai Tongan Ugandan Ukrainian

Vietnamese Yemeni Other: _____

What is your (your child's) preferred language? Check one:

Amharic Arabic Balochi/Baluchi Burmese Cantonese Chinese (unspecified) Chamorro Chuukese

Dari English Farsi/Persian Fijian Filipino/Pilipino French German Hindi Hmong Japanese

Karen Khmer/Cambodian Kinyarwanda Korean Kosraean Lao Mandarin Marshallese Mixteco

Nepali Oromo Panjabi/Punjabi Pashto Portuguese Romanian/Rumanian Russian Samoan

Sign languages Somali Spanish/Castilian Swahili/Kiswahili Tagalog Tamil Telugu Thai Tigrinya

Ukrainian Urdu Vietnamese Other language: _____ Patient declined to respond Unknown

Interpreter needed Yes No Unk

EMPLOYMENT AND SCHOOL

Employed Yes No Unk Occupation _____ Industry _____
 Employer _____ Work site _____ City _____

Student/Day care Yes No Unk
 Type of school Preschool/day care K-12 College Graduate School Vocational Online Other
 School name _____ School address _____
 City/State/County _____ Zip _____ Phone number _____ Teacher's name _____

COMMUNICATIONS

Primary HCP name _____ Phone _____
 OK to talk to patient (If Later, provide date) Yes Later ___/___/___ Never
 Date of interview attempt ___/___/___ Complete Partial Unable to reach Patient could not be interviewed
 Alternate contact: Parent/Guardian Spouse/Partner Friend Other _____
 Name _____ Phone _____

Outbreak related Yes No LHJ Cluster ID _____ Cluster Name _____

CLINICAL INFORMATION

Complainant ill Yes No Unk Symptom Onset ___/___/___ Derived Diagnosis date ___/___/___
 Illness duration _____ Days Weeks Months Years Illness is still ongoing Yes No Unk

Clinical Features
Y N Unk
 Diarrhea (3 or more loose stools within a 24 hour period) Onset ___/___/___
 Diarrhea of > 72 hours duration
 Abdominal pain or cramps
 Nausea
 Vomiting
 Anorexia (loss of appetite)
 Weight loss with illness
 Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____ °F

Predisposing Conditions

Y N Unk
 Immunosuppressive therapy or condition, or disease Specify _____

Hospitalization

Y N Unk
 Hospitalized at least overnight for this illness Facility name _____
 Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
 Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
 Still hospitalized As of ___/___/___

Y N Unk

Died of this illness Death date ___/___/___ Please fill in the death date information on the Person Screen

RISK AND RESPONSE (Ask about exposures 1-12 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk
 Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____
 Does the case know anyone else with similar symptoms or illness
 Onset date, shared meals, relationship, etc. _____
 Contact with lab confirmed case
 Childcare/Day care
 Household
 Sexual
 Other _____

Y N Unk

- Attends childcare or preschool Locations/date of exposure _____
 Contact with diapered or incontinent child or adult

Food Exposure - Food exposure timeframe: 1-12 days prior to onset of illness

Sources of food IN home - During exposure timeframe did you (your child) eat foods from:

- | | |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> (1) Grocery stores or supermarkets | <input type="checkbox"/> (7) Small markets/mini markets (convenience stores, gas stations, etc) |
| <input type="checkbox"/> (2) Home delivery grocery services (CSA, grocery delivery, Amazon Fresh, Peapod, etc) | <input type="checkbox"/> (8) Health food stores or co-ops |
| <input type="checkbox"/> (3) Fish or meat specialty shops (butcher shop, etc) | <input type="checkbox"/> (9) Ethnic specialty markets (Mexican, Asian, Indian) |
| <input type="checkbox"/> (4) Warehouse stores (Costco, Sam's Club, etc.) | <input type="checkbox"/> (10) Farmers markets, roadside stands, open-air markets, food purchased directly from a farm |
| <input type="checkbox"/> (5) Meal delivery services (Blue Apron, Meals on Wheels, Schwan's, NutriSystem, etc) | <input type="checkbox"/> (11) Other _____ |
| <input type="checkbox"/> (6) Live animal market, custom slaughter facility | |

Type of Business (enter number next to choices above)	Business name	Address/location

Sources of food outside home - During exposure timeframe did you (your child) eat foods from:

- | | |
|------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> (1) Fast casual (Chipolte, Panera, etc) | <input type="checkbox"/> (10) Chinese, Japanese, Vietnamese, other Asian-style |
| <input type="checkbox"/> (2) Fast food (McDonald's, Burger King, Wendy's) | <input type="checkbox"/> (11) All-you-can-eat buffet |
| <input type="checkbox"/> (3) Sandwich shop, deli | <input type="checkbox"/> (12) Breakfast, brunch, diner, or café |
| <input type="checkbox"/> (4) Jamaican, Cuban, or Caribbean | <input type="checkbox"/> (13) Middle Eastern, Greek/Mediterranean, Arabic, Lebanese, African |
| <input type="checkbox"/> (5) Ready-to-eat prepared food from grocery or deli | <input type="checkbox"/> (14) Any takeout from a restaurant |
| <input type="checkbox"/> (6) An event where food was served (catered event, festival, church, or community meal) | <input type="checkbox"/> (15) Healthy restaurant (vegetarian, vegan, salad-based) |
| <input type="checkbox"/> (7) Mexican, Salvadorian, other Hispanic/Latino-style | <input type="checkbox"/> (16) Salad bar at a grocery store or restaurant |
| <input type="checkbox"/> (8) Food trucks, food stalls/stands | <input type="checkbox"/> (17) Other _____ |
| <input type="checkbox"/> (9) School, hospital, senior center, or other institutional setting | |

Type of Business (enter number next to choices above)	Restaurant/venue name	Date	Time of meal (Breakfast, Brunch, Lunch, Happy Hour, Dinner, Other)	Food ordered/eaten	Address/location
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		

Y M N Unk

Any food sampled (grocery, warehouse stores, food court, etc.) _____

Consumed any of the following during exposure period

Eggs and Dairy

Y M N Unk

Raw/unpasteurized milk (including cow, goat, sheep, etc.)
 Dairy animal type Cow Goat Sheep Other _____
 Type, variety or brand _____

Any raw/unpasteurized milk left over

Cheese made from raw/unpasteurized milk including homemade, farm-fresh, and door-to-door cheeses
 Type, variety or brand _____

Any raw/unpasteurized cheese left over

Other raw/unpasteurized dairy product (e.g., yogurt, kefir, ice cream)
 Type, variety or brand _____

Any raw/unpasteurized dairy product left over

Seafood

Y M N Unk

Fish and seafood Type _____

Raw or undercooked shellfish

Drinks

Y M N Unk

Juices and smoothies

Juice or cider Type _____

Unpasteurized juices or cider Type _____

Water Exposure

Y N Unk

Describe

Source of drinking water known

Bottled water _____

Public water system _____

Individual well _____

Shared well _____

Other _____

Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring) _____

Any recreational water exposure (e.g., lake, river, pool, waterpark) _____

Water site name/location _____

Treatment Treated Untreated Unk

Type Lake River Pool/hot tub Wading pool Fountain Waterpark

Splash pad/water playground Other

Animal Exposure

Y N Unk

Any contact with pet animals at home or elsewhere

Cats or kittens _____

Dogs or puppies _____

Any sick pets _____

Any new household pets in the last month _____

Any contact with farm animals, including chickens or ducks

Cows or calves

Donkeys

Goats

Horses or ponies

Sheep

Pigs or swine

Other animal contact _____

Applied or handled compost/manure

Contact with animal manure/droppings other than dogs or cats _____

Animal Settings

Y N Unk

- Live on a farm or other setting that has farm animals _____
- Household member works with animals _____
- Hunting/butchering _____
- Work with animals or animal products (e.g., research, farming, veterinary medicine, animal slaughter)

Exposure to any of the following facilities/settings even if no direct animal contact

	Y	N	Unk	Describe	Type of exposure
Research facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Slaughterhouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Veterinary facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit

Visited or worked on any of the following settings even if no direct animal contact

	Y	N	Unk	Location, animals, etc.	Type of exposure
Petting zoo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Zoo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Dairy farm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Other farm contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Agricultural 'Farm and Feed' store	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
County/state fairs, 4-H events, or similar events where animals are present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Pet store or other places where animals are sold or adopted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Attended any school events, birthday parties, or similar events with animals/pets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Other setting with animals Describe _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit

Sexual Exposure

Y N Unk

- Any type of sexual contact with others during the exposure period
- Number of sexual partners during exposure period _____ Female _____ Male

Exposure and Transmission Summary

Y N Unk

- Epi-linked to a confirmed case**
- Outbreak related

Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure type Foodborne Waterborne Animal related Person to person Sexual
 Health care associated Unk Other _____

Describe _____

Suspected exposure setting Daycare/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____

Describe _____

Exposure Summary _____

Public Health Issues**Y N Unk**

- Hygiene education provided
 Follow-up of household members
 Work or childcare restriction for case
 Work or childcare restriction for symptomatic contacts

Public Health Interventions/Actions**Y N Unk**

- Childcare inspection
 Test symptomatic contacts
 Water supply implicated
 Testing of home/Other water supply
 Letter sent Date ___/___/___ Batch date ___/___/___
 Any other public health action _____

TREATMENT**Y N Unk**

- Did patient receive prophylaxis/treatment
Specify antibiotic _____
Number of days actually taken _____

NOTES**LAB RESULTS**Lab report information**Lab report reviewed – LHJ**

WDRS user-entered lab report note

Submitter _____

Performing lab for entire report _____

Referring lab _____

Specimen**Specimen identifier/accession number** _____**Specimen collection date** ___/___/___ **Specimen received date** ___/___/___**WDRS specimen type** _____

WDRS specimen source site _____

WDRS specimen reject reason _____

Test performed and result**WDRS test performed** _____**WDRS test result, coded** _____

WDRS test result, comparator _____

WDRS result, numeric only (enter only if given, including as necessary **Comparator** and **Unit of measure**) _____

WDRS unit of measure _____

Test method _____

WDRS interpretation code _____

Test result – Other, specify _____

WDRS result summary Positive Negative Indeterminate Equivocal Test not performed Pending

Test result status Final results; Can only be changed with a corrected result

Preliminary results

Record coming over is a correction and thus replaces a final result

Results cannot be obtained for this observation

Specimen in lab; results pending

Result date ___/___/___

Upload document

Ordering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email doh.information@doh.wa.gov.