



# Cyclosporiasis

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 \_\_\_\_\_ LHM Case ID (optional) \_\_\_\_\_

LHM 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 \_\_\_\_\_ LHM \_\_\_\_\_

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 date \_\_\_/\_\_\_/\_\_\_
  - Watery diarrhea**
  - Abdominal pain or cramps**
  - Nausea
  - Vomiting
  - Weight loss with illness Baseline weight \_\_\_\_\_ Number of pounds lost \_\_\_\_\_
  - Abdominal bloating or gas**
  - Any fever, subjective or measured** If yes, Temp measured?  Yes  No Highest measured temp \_\_\_\_\_°F
  - Low grade fever
  - Anorexia (loss of appetite)
  - Fatigue
  - Malaise
  - Myalgia (muscle aches or pain)

**Predisposing Conditions**

- Y N Unk**
- Immunosuppressive therapy, 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 \_\_\_/\_\_\_/\_\_\_
  - Mechanical ventilation or intubation required
  - Still hospitalized As of \_\_\_/\_\_\_/\_\_\_

**Y N Unk**

- Died of this illness Death date \_\_\_/\_\_\_/\_\_\_ *Please fill in the death date information on the Person Screen*
- Autopsy performed
- Death certificate lists disease as a cause of death or a significant contributing condition

**RISK AND RESPONSE (Ask about exposures 1-14 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. \_\_\_\_\_

**Food Exposure - Food exposure timeframe: 1-14 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**

**Produce**

**Y M N Unk**

Fresh herbs (e.g., cilantro, basil, parsley, chives, mint, other)

Cilantro

Basil

Sweet basil

Thai basil (i.e. green leaves and purple stems)

Purple basil (i.e. purple leaves and stems)

Parsley

Sage

Thyme

Dill

Chives

Mint

Oregano

Rosemary

Other fresh herbs \_\_\_\_\_

Leafy greens (arugula, mesclun, spinach, lettuce)

Arugula

Mesclun (spring mix, field greens, baby greens, gourmet salad mix)

Fresh spinach

Romaine lettuce

Other type of lettuce \_\_\_\_\_

Unknown type of lettuce \_\_\_\_\_

Fresh fruit (berries, melons, citrus, tropical fruit)

Berries

Black raspberries

Blackberries

Blueberries

Golden raspberries

Raspberries

Strawberries

Unknown type of berry

Other \_\_\_\_\_

Other fresh produce

Snow peas (flat, shiny pea pods containing tiny peas)

Fruit other than berries \_\_\_\_\_

Other type of fresh produce \_\_\_\_\_

Unknown type of fresh produce \_\_\_\_\_

**Water Exposure**

**Y N Unk**

**Describe**

Source of drinking water known

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

**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  Unk  Other \_\_\_\_\_  
 Describe \_\_\_\_\_

Suspected exposure setting  Day care/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 Interventions/Actions**

**Y N Unk**

- Commercial product implicated
- Initiate trace-back investigation
- Letter sent Date \_\_\_/\_\_\_/\_\_\_ Batch date \_\_\_/\_\_\_/\_\_\_

**TREATMENT**

**Y N Unk**

- Is case-patient allergic to (or intolerant of) sulfa drugs
- Did patient receive prophylaxis/treatment  
 Specify medication \_\_\_\_\_  Fungal/Parasitic  Other

**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 \_\_\_\_\_

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