Washington State Department of Health

Cholera

County

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other 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
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

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

Investigation start date ___/___/___

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk

Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

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 _____

REPORT SOURCE

Initial report source _____

LHJ _____

Reporter organization _____

Reporter name _____

Reporter phone _____

All reporting sources (list all that apply)

_____

_____

_____

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 _____

Contact name _____

Contact phone _____

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

Signs and Symptoms

Y	N	Unk	
☐	☐	☐	**Any fever**, subjective or measured Temp measured? ☐ Yes ☐ No Highest measured temp _____ºF
☐	☐	☐	**Diarrhea** *(3 or more loose stools within a 24 hour period)* Onset date ___/___/___ Max # of stools in 24 hrs _____
☐	☐	☐	Bloody diarrhea
☐	☐	☐	**Abdominal pain or cramps**
☐	☐	☐	**Vomiting**
☐	☐	☐	**Cellulitis** Site of cellulitis _____
☐	☐	☐	Bullae (blisters) Site of bullae _____
☐	☐	☐	Myalgia (muscle aches or pain)
☐	☐	☐	Headache
☐	☐	☐	**Shock**
☐	☐	☐	Any complication _____

Predisposing Conditions

Y N Unk

☐ ☐ ☐ Antacid use in 30 days prior to onset Antacid _____
☐ ☐ ☐ H2 blocker or ulcer medication (e.g., Tagamet, Zantac, Omeprazole) use in 30 days prior to onset
Medication _____
☐ ☐ ☐ Chemotherapy in 30 days prior to onset Treatment _____ Treatment date ___/___/___
☐ ☐ ☐ Chronic heart disease
☐ ☐ ☐ Heart failure
☐ ☐ ☐ Gastric surgery or gastrectomy in past
☐ ☐ ☐ Peptic ulcer
☐ ☐ ☐ Liver disease Type _____
☐ ☐ ☐ Chronic kidney disease Type _____
☐ ☐ ☐ Diabetes mellitus
☐ ☐ ☐ Insulin use
☐ ☐ ☐ Hematologic disease
☐ ☐ ☐ Immunodeficiency
☐ ☐ ☐ Immunosuppressive therapy or condition, or disease Specify _____
☐ ☐ ☐ Malignancy Type _____
☐ ☐ ☐ Alcoholism
☐ ☐ ☐ Other underlying medical conditions _____

Vaccination

Y N Unk

☐ ☐ ☐ Cholera vaccine in past Specify most recent type ☐ Oral ☐ Parenteral Most recent date received ___/___/___

Vaccine information available ☐ Yes ☐ No
Date of vaccine administration ___/___/___ Vaccine administered (Type) _____
Vaccine lot number _____ Administering provider _____

Culture Information

Y N Unk

☐ ☐ ☐ Confirmed at state or federal public health lab

Hospitalization

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
Disposition ☐ Another acute care hospital Facility name _____
☐ Died in hospital
☐ Long term acute care facility Facility name _____
☐ Long term care facility Facility name _____
☐ Non-healthcare (home) ☐ Unk ☐ Other _____
☐ ☐ ☐ 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
Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital) ☐ Emergency department (ED)
☐ Inpatient ward ☐ ICU ☐ Other _____

RISK AND RESPONSE (Ask about exposures 7 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Y N Unk

☐ ☐ ☐ Foreign travel
If Yes to "Foreign travel",
☐ ☐ ☐ Had the patient been educated in cholera prevention measures before travel
Which source(s) of information received (check all that apply) ☐ Pre-travel clinic ☐ Airport departure gate
☐ Newspaper ☐ Friends ☐ Private physician ☐ Health department ☐ Travel agency
☐ CDC traveler's hotline ☐ Other _____
What was the patient's reason for travel ☐ To visit relatives/friends ☐ Business ☐ Tourism ☐ Military ☐ Unk
☐ Other _____

Case Name ______________________________ LHJ Case ID ______________________________

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

☐ ☐ ☐ Known contaminated food product ______________________

Food Exposure

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

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

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:

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

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**
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ________		
			☐ Bfast ☐ Bru ☐ Lun ☐ HH ☐ Din ☐ Other ________		

Y M N Unk
☐ ☐ ☐ ☐ Any food sampled (grocery, warehouse stores, food court, etc.) _____

Y N Unk
☐ ☐ ☐ Consumed shellfish or seafood during the 7 days before onset of illness

Type	Eaten Y N U	Eaten Raw Y N U	Multiple Dates Y N U	Last date consumed	Type	Eaten Y N U	Eaten Raw Y N U	Multiple Dates Y N U	Last date consumed
Clams	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___	Mussels	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___
Crabs	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___	Oysters	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___
Crawfish	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___	Scallops	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___
Fish	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___	Shrimp	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___
Lobster	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___	Other shellfish (specify)	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	___/___/___

Please fill in below if investigating specific seafood
Type of seafood being investigated (from list above) _____
Date of consumption of the seafood being investigated ___/___/___ Amount consumed _____
How prepared ☐ Fully cooked ☐ Undercooked ☐ Raw ☐ Unknown
Additional relevant information on product preparation (e.g., specific variety of seafood consumed and plating)

Y N Unk
☐ ☐ ☐ Any dining partners consume the same seafood
☐ ☐ ☐ Any become ill Describe _____
How was the seafood obtained ☐ Harvested by the patient or a friend of the patient ☐ Oyster bar or restaurant
☐ Seafood market ☐ Truck or roadside vendor ☐ Food store ☐ Other
Name of location where seafood was obtained _____ Phone # _____
Address _____ Date received ___/___/___
Y N Unk
☐ ☐ ☐ Was this seafood imported from another country Exporting country _____
☐ ☐ ☐ Was this business inspected as part of this investigation
☐ ☐ ☐ Was there evidence of improper handling or storage (check all that apply)
☐ Holding temperature violation ☐ Cross-contamination ☐ Co-mingling of live and dead shellfish
☐ Improper storage ☐ Other _____
How were the shellfish distributed to the business ☐ Shellstock (sold in shell) ☐ Shucked ☐ Unk ☐ Other _____
Y N Unk
☐ ☐ ☐ Are shipping tags available from the suspected lot *If Yes, attach tags to the record*
☐ ☐ ☐CDC surveillance form completed

Exposure and Transmission Summary
Y N Unk
☐ ☐ ☐ **Epi-linked to a confirmed case**

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 ☐ Person to person ☐ Sexual ☐ Unk
☐ Other _____
Describe _____
Suspected exposure setting ☐ Home ☐ Work ☐ College ☐ Military ☐ Place of worship ☐ International travel
☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel
☐ Other _____
Describe _____

Case Name _____ LHJ Case ID _____

Exposure summary

Suspected transmission type ☐ Foodborne ☐ Waterborne ☐ Person to person ☐ Sexual ☐ Unk
☐ Other _____
Describe _____
Suspected transmission setting ☐ Home ☐ Work ☐ College ☐ Military ☐ Place of worship ☐ International travel
☐ Out of state travel ☐ Transit ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel
☐ Other _____
Describe _____

Public Health Issues

Y	N	Unk	
☐	☐	☐	Does patient have contact with a day care
☐	☐	☐	Non-occupational food handling (e.g., potlucks, receptions) during contagious period
☐	☐	☐	Employed as a food handler
☐	☐	☐	Employed in childcare or preschool

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions

Y	N	Unk	
☐	☐	☐	Test symptomatic contacts
☐	☐	☐	Patient education provided
☐	☐	☐	Letter sent Date ___/___/___ Batch date ___/___/___
☐	☐	☐	Any other public health action _____

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious ☐ Yes ☐ No ☐ Unk
Settings and details (check all that apply)
☐ Daycare ☐ School ☐ Airport ☐ Hotel/Motel/Hostel ☐ Transit ☐ Healthcare ☐ Home ☐ Work ☐ College
☐ Military ☐ Correctional facility ☐ Place of worship ☐ International travel ☐ Out of state travel ☐ LTCF
☐ Homeless/shelter ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

If list of contacts is known, please fill out contact tracing form Question Package

TREATMENT

Y	N	Unk	
☐	☐	☐	Did patient receive prophylaxis/treatment

Specify medication _____ ☐ Antibiotic ☐ Other
Number of days actually taken _____ Treatment start date ___/___/___ Treatment end date ___/___/___
Prescribing provider _____

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 _____