



# Cholera

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

**Signs and Symptoms**

**Y N Unk**

- Any fever**, subjective or measured Temp measured?  Yes  No Highest measured temp \_\_\_\_\_ °F  
   **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 \_\_\_\_\_

**Y N Unk**

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:	<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 ___/___/___

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

**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:

- |  |  |
|--|--|
| <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.) \_\_\_\_\_

**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	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	__/__/__	Mussels	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	__/__/__
Crabs	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	__/__/__	Oysters	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	__/__/__
Crawfish	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	__/__/__	Scallops	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	__/__/__

Fish	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___	Shrimp	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___
Lobster	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___	Other shellfish (specify)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	___/___/___

*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 \_\_\_\_\_

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)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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  PendingTest 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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