



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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