



Shellfish Poisoning

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
 Disease type Paralytic Shellfish Poisoning (PSP) Domoic Acid Shellfish Poisoning (DASP)
 Diarrhetic Shellfish Poisoning (DSP)

Clinical Features

Y N Unk
 Vomiting, diarrhea, and cramps within 24 hours of shellfish ingestion
 Diarrhea (3 or more loose stools within a 24 hour period)
 Diarrhea or other gastrointestinal symptom within 0.5-36 hours of shellfish consumption
 Abdominal pain or cramps
 Neurologic symptoms (e.g. paresthesia, ataxia, cranial nerve abnormalities, paralysis) within minutes to hours of shellfish consumption
 Bulbar weakness (cranial nerve abnormalities)
 Ptosis (drooping eyelids)
 Blurred or double vision
 Swallowing or speech difficulty
 Dysphonia

- Mouth tingling or numbness**
- Paralysis or weakness
- Ascending
- Descending
- Asymmetric
- Symmetric
- Acute
- Ataxia**
- Extremities numb**
- Excessive respiratory secretions**
- Dyspnea (shortness of breath)
- Respiratory failure**
- Cardiac arrhythmias, ECG abnormalities**
- Confusion**
- Memory loss**
- Seizure new with disease**
- Coma**

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 .5-36 hours 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 sharing shellfish with similar symptoms or illness
- Bivalve shellfish (oysters, clams, mussels, etc.)** County of location collected _____
 Type Oysters Clams Geoducks Mussels Scallops Cockles Barnacles
 Other _____

Exposure and Transmission Summary

Y N Unk

- Epidemiologic link to a confirmed human 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

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 Issues**Y N Unk** Notify others sharing exposure**Public Health Interventions/Actions****Y N Unk** Commercial product implicated Initiate trace-back investigation Source (business name, telephone, product) _____ Letter sent Date ___/___/___ Batch date ___/___/___ Any other public health action _____**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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____