



Washington State Department of Health
WATERBORNE DISEASE CASE INVESTIGATION WORKSHEET

COMPLAINT INFORMATION

Date of complaint ____/____/____	Complainant name	Address	(H) Phone (C) Phone
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SUSPECTED WATER EXPOSURE OR ACTIVITY

# persons ill: _____	If ≥ 1 person ill: Do all ill persons live together? <input type="checkbox"/> Y <input type="checkbox"/> N Do all ill persons work together? <input type="checkbox"/> Y <input type="checkbox"/> N # meals in common: _____	If <u>only 1</u> person ill: Any recent travel: <input type="checkbox"/> Y <input type="checkbox"/> N Contact with known ill person <input type="checkbox"/> Y <input type="checkbox"/> N Contact with animal <input type="checkbox"/> Y type: _____ <input type="checkbox"/> N
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Suspected place of water exposure including address	Exposure date: ____/____/____	# ill persons sharing exposure: _____
	Exposure time: _____	Total # persons sharing exposure: _____

CLINICAL DATA

Name				
Phone				
Address				
Date interviewed				
Date of birth or age				
Sex	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk <input type="checkbox"/> Other
Date and time of water exposure	Date Time	Date Time	Date Time	Date Time
First major symptom	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other <input type="checkbox"/> Not Ill	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other <input type="checkbox"/> Not Ill	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other <input type="checkbox"/> Not Ill	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other <input type="checkbox"/> Not Ill
Date and time of first episode of vomiting, diarrhea or major symptom (describe)	Date Time	Date Time	Date Time	Date Time
Incubation (hours)				
Date & time of last episode of vomiting, diarrhea, or major symptom	Date Time	Date Time	Date Time	Date Time
Duration (hours or days)				

SIGNS OR SYMPTOMS – (+) if person experienced symptom, (-) if person did not experience symptom

Vomiting				
Diarrhea				
Avg # stools/24 hrs				
Bloody diarrhea				
Fever				
Abdominal cramps				
Rash				
Other (list)				

HEALTHCARE PROVIDER (HCP) VISITS AND LABORATORY - (+) if Yes, (-) if No

HCP visit (if yes, provider name)				
ER visit (if yes, facility name)				
Hospitalization (if yes, facility name)				
Specimen submitted	<input type="checkbox"/> Y type: _____ <input type="checkbox"/> N	<input type="checkbox"/> Y type: _____ <input type="checkbox"/> N	<input type="checkbox"/> Y type: _____ <input type="checkbox"/> N	<input type="checkbox"/> Y type: _____ <input type="checkbox"/> N
Lab results				

