



Vibriosis (non-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 _____ LHJ Case ID (optional) _____

LHJ 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
 Otitis externa
 Wound infection
 Shock
 Other symptoms consistent with this illness _____

Y N Unk 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 Disease _____
 Diabetes mellitus
 Hematologic disease
 Immunodeficiency
 Immunosuppressive therapy or condition, or disease Specify _____
 Malignancy Type _____
 Alcoholism
 Other underlying medical conditions _____

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 _____
 Died of this illness Death date ___/___/___ Please fill in the death date information on the Person Screen

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 ____/____/____

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. _____
- Known contaminated food product _____

Water Exposure

Y N Unk

- Skin exposed to water or aquatic organisms in 7 days before illness began
- Skin exposed to a body of water (fresh, salt or brackish in 7 days before illness began
Date ____/____/____ Time _____ Location _____
Type Salt Fresh Brackish Unk Other _____
- Other contact with marine or freshwater life Date ____/____/____ Time _____
- Skin exposed to drippings from raw or live seafood Date ____/____/____ Time _____
- Did case incur a wound before or during exposure No Ukn
 - Yes, had a pre-existing wound
 - Yes, sustained a wound (during exposure)
 - Yes, uncertain if wound was new or old (at time of exposure)
 Date of injury or wound ____/____/____ Describe _____
 Anatomic site of injury or wound (e.g., head, arm) _____

Food Exposure - Food exposure timeframe: 7 days prior to onset of illness

Y N Unk

- Consumed shellfish or seafood during the 7 days before onset of illness

Type	Eaten			Eaten Raw			Multiple Dates			Last date consumed
	Y	N	U	Y	N	U	Y	N	U	
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"/>	____/____/____
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"/>	____/____/____
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"/>	____/____/____
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"/>	____/____/____
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)

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 or probable 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 Animal related 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

Public Health Interventions/Actions

Y N Unk

Restaurant inspection Name/Location _____

Commercial product implicated

Initiate trace-back investigation

Letter sent Date ___/___/___ Batch date ___/___/___

Any other public health action

TREATMENT

Y N Unk

Did patient receive prophylaxis/treatment

Specify antibiotic _____

Treatment start date ___/___/___ Treatment end date ___/___/___

NOTES

LAB RESULTSLab 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 _____

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