



**Immediately notify  
DOH Communicable  
Disease Epidemiology  
Phone: 877-539-4344**

LHJ Use ID \_\_\_\_\_

Reported to DOH Date \_\_\_/\_\_\_/\_\_\_

LHJ Classification  Confirmed

By:  Lab  Clinical

Epi Link: \_\_\_\_\_

Outbreak-related

LHJ Cluster# \_\_\_\_\_

LHJ Cluster Name: \_\_\_\_\_

DOH Outbreak # \_\_\_\_\_

# Cholera

County \_\_\_\_\_

## REPORT SOURCE

LHJ notification date \_\_\_/\_\_\_/\_\_\_ Investigation start date \_\_\_/\_\_\_/\_\_\_

Reporter (check all that apply)  Lab  Hospital  HCP  
 Public health agency  Other

Reporter name \_\_\_\_\_

Reporter phone \_\_\_\_\_

Primary HCP name \_\_\_\_\_

Primary HCP phone \_\_\_\_\_

OK to talk to case?  Yes  No  DK Date of interview \_\_\_/\_\_\_/\_\_\_

## PATIENT INFORMATION

Name (last, first) \_\_\_\_\_

Address \_\_\_\_\_  Homeless

City/State/Zip \_\_\_\_\_

Phone(s)/Email \_\_\_\_\_

Alt. contact  Parent/guardian  Spouse  Other Name: \_\_\_\_\_

Zip code (school or occupation): \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation/grade \_\_\_\_\_

Employer/worksite \_\_\_\_\_ School/child care name \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Gender  F  M  Other  Unk

Ethnicity  Hispanic or Latino  
 Not Hispanic or Latino  Unk

Race (check all that apply)

Amer Ind/AK Native  Asian  
 Native HI/other PI  Black/Afr Amer  
 White  Other  Unk

## CLINICAL INFORMATION

Onset date: \_\_\_/\_\_\_/\_\_\_  Derived Diagnosis date: \_\_\_/\_\_\_/\_\_\_ Illness duration: \_\_\_ days

### Signs and Symptoms

Y N DK NA

**Diarrhea** Maximum # stools in 24 hours: \_\_\_\_\_

Bloody diarrhea

Watery diarrhea

Abdominal cramps or pain

Nausea

**Vomiting**

**Fever** Highest measured temp (°F): \_\_\_\_\_  
 Oral  Rectal  Other: \_\_\_\_\_  Unk

Headache

Muscle aches or pain (myalgia)

Rash

### Predisposing Conditions

Y N DK NA

Antibiotic use in 30 days prior to onset

Antacid use regularly

H2 blocker or ulcer medication (e.g. Tagamet, Zantac, Omeprazole)

Immunosuppressive therapy or disease

Systemic corticosteroids in last 30 days

Chemotherapy 30 days prior to onset

Cancer, solid tumors, or hematologic malignancies

Radiotherapy in last 30 days

Insulin-dependent diabetes

Chronic diabetes

Gastric surgery or gastrectomy in past

Chronic heart disease

Preexisting heart failure

Chronic kidney disease

Chronic liver disease

Peptic ulcer

Alcoholism

### Clinical Findings

Y N DK NA

Hematologic disease

Shock

Other clinical findings consistent with illness

Specify: \_\_\_\_\_

Admitted to intensive care unit

### Hospitalization

Y N DK NA

Hospitalized at least overnight for this illness

Hospital name \_\_\_\_\_

Admit date \_\_\_/\_\_\_/\_\_\_ Discharge date \_\_\_/\_\_\_/\_\_\_ exception

Y N DK NA

Died from illness Death date \_\_\_/\_\_\_/\_\_\_

Autopsy Place of death \_\_\_\_\_

### Vaccination History

Y N DK NA

Cholera vaccine in past

Cholera vaccine type \_\_\_\_\_

Date of last cholera vaccine (mm/yyyy) \_\_\_/\_\_\_/\_\_\_

### Laboratory

Collection date \_\_\_/\_\_\_/\_\_\_

Source \_\_\_\_\_

P = Positive O = Other  
N = Negative NT = Not Tested  
I = Indeterminate

P N I O NT

**Toxigenic cholera culture (stool, vomitus)**

**Serology for recent toxigenic cholera infection**

Serotype/Group: \_\_\_\_\_

Species/Organism: \_\_\_\_\_

**INFECTION TIMELINE**

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:	<b>Exposure period</b>		o n s e t	<b>Contagious period</b>	
	-5	-0		days to (rarely) months	
Calendar dates:	[ ]	[ ]	[ ]	[ ]	

**EXPOSURE\* (Refer to dates above)**

Y N DK NA

- Travel out of the state, out of the country, or outside of usual routine  
Out of:  County  State  Country  
Destinations: \_\_\_\_\_  
Date left: \_\_\_\_\_  
Date returned: \_\_\_\_\_
- Case knows anyone with similar symptoms
- Contact with lab confirmed case
- Contact with diapered or incontinent child or adult
- Shellfish or seafood  
County or location shellfish collected: \_\_\_\_\_
- Raw or undercooked shellfish or seafood  
 **CDC surveillance report form completed (see note below)**
- Handled raw seafood

Y N DK NA

- Known contaminated food product
- Group meal (e.g. potluck, reception)
- Food from restaurants  
Restaurant name/location: \_\_\_\_\_
- Y N DK NA**
- Source of drinking water known  
 Individual well  Shared well  
 Public water system  Bottled water  
 Other: \_\_\_\_\_
- Drank untreated/unchlorinated water (e.g. surface, well)
- Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)
- Sewage or human excreta
- Contact with recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor)  
Specify country: \_\_\_\_\_

Where did exposure probably occur?  In WA (County: \_\_\_\_\_)  US but not WA  Not in US  Unk

Exposure details: \_\_\_\_\_

- No risk factors or exposures could be identified
- Patient could not be interviewed

**Note: CDC surveillance report form is also required. The CDC surveillance report form can be found at:**

[http://www.cdc.gov/nationalsurveillance/PDFs/CDC5279\\_COVISvibriosis.pdf](http://www.cdc.gov/nationalsurveillance/PDFs/CDC5279_COVISvibriosis.pdf)

**PATIENT PROPHYLAXIS / TREATMENT**

Y N DK NA

- Antibiotics prescribed for this illness Antibiotic name: \_\_\_\_\_  
Date antibiotic treatment began: \_\_\_/\_\_\_/\_\_\_ # days antibiotic actually taken: \_\_\_\_\_

**PUBLIC HEALTH ISSUES**

Y N DK NA

- Employed as food worker
- Non-occupational food handling (e.g. potlucks, receptions) during contagious period
- Employed in child care or preschool
- Attends child care or preschool
- Household member or close contact in sensitive occupation or setting (HCW, child care, food)

**PUBLIC HEALTH ACTIONS**

- Prophylaxis of appropriate contacts recommended  
Number recommended prophylaxis: \_\_\_\_\_  
Number receiving prophylaxis: \_\_\_\_\_  
Number completing prophylaxis: \_\_\_\_\_
- Exclude case from sensitive occupations (HCW, food, child care) or situations
- Test symptomatic contacts
- Notify others sharing exposure
- Other, specify: \_\_\_\_\_

**NOTES**

Investigator _____	Phone/email: _____	Investigation complete date ___/___/___
Local health jurisdiction _____		Record complete date ___/___/___