



Vibriosis (non-cholera)

County _____

LHJ Use ID _____
 Reported to DOH Date ___/___/___
 LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Epi Link: _____

Outbreak-related
 LHJ Cluster# _____
 LHJ Cluster Name: _____
 DOH Outbreak # _____

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 | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea Maximum # stools in 24 hours: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bloody diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Watery diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal cramps or pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Fever Highest measured temp (°F): _____ |
| | | | <input type="checkbox"/> | Oral <input type="checkbox"/> Rectal <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscle aches or pain (myalgia) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rash |

Predisposing Conditions

- | Y | N | DK | NA | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immunosuppressive therapy or disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Systemic corticosteroids in last 30 days |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, solid tumors, or hematologic malignancies |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy 30 days prior to onset |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Insulin-dependent diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Preexisting heart failure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastric surgery or gastrectomy in past |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Peptic ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | H2 blocker or ulcer medication (e.g. Tagamet, Zantac, Omeprazole) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Radiotherapy in last 30 days |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Antibiotic use in 30 days prior to onset |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acute injury or wound Date: ___/___/___ |
| | | | <input type="checkbox"/> | Anatomic site: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcoholism |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Antacid use regularly |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hematologic disease |

Clinical Findings

- | Y | N | DK | NA | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sepsis syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shock |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cellulitis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cutaneous ulcer |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other clinical findings consistent with illness |
| | | | | Specify: _____ |

Hospitalization

- | Y | N | DK | NA | |
|---|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hospitalized at least overnight for this illness |
| Hospital name _____ | | | | |
| Admit date ___/___/___ Discharge date ___/___/___ exception | | | | |
| Y | N | DK | NA | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Died from illness Death date ___/___/___ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autopsy Place of death _____ |

Laboratory

Collection date ___/___/___
 Source _____

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

P N I O NT

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pathogenic <i>Vibrionaceae</i> species (except toxigenic <i>V. cholerae</i>) culture (clinical specimen) |
| Specimen source: <input type="checkbox"/> Stool <input type="checkbox"/> Wound | | | | | |
| <input type="checkbox"/> Other: _____ | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <i>V. parahaemolyticus</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <i>V. vulnificus</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <i>V. alginolyticus</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <i>V. fluvialis</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Non-toxigenic <i>V. cholerae</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other pathogenic non-cholera species: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Detection of pathogenic <i>Vibrionaceae</i> using a non-culture based method [Probable] |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food specimen culture |

INFECTION TIMELINE

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

Exposure period
Days from onset:

o
n
s
e
t

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
Dates/Locations: _____
- Case knows anyone with similar symptoms
- Epidemiologic link to a confirmed human case**
- Contact with lab confirmed case
 Casual Household Sexual
 Needle use Other: _____
- Shellfish or seafood
County or location shellfish collected: _____
- Raw or undercooked shellfish or seafood
 CDC surveillance report form completed (see note below)

Y N DK NA

- Handled raw seafood
- 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)
- Skin exposed to water or aquatic organisms
- 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

PATIENT PROPHYLAXIS / TREATMENT

Y N DK NA

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

PUBLIC HEALTH ISSUES

PUBLIC HEALTH ACTIONS

- Initiate trace-back investigation
- Restaurant inspection
- Other, specify: _____

NOTES

Investigator _____ Phone/email: _____

Investigation complete date ___/___/___

Local health jurisdiction _____

Record complete date ___/___/___