



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

Cholera

County _____

LHJ Use ID _____

Reported to DOH Date ___/___/___

LHJ Classification Confirmed

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

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:	Exposure period		o n s e t	Contagious period	
	-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.doh.wa.gov/notify/forms/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 ___/___/___