



# Shellfish Poisoning

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 \_\_\_\_\_ LHM Case ID (optional) \_\_\_\_\_

LHM 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  
 Disease type  Paralytic Shellfish Poisoning (PSP)  Domoic Acid Shellfish Poisoning (DASP)  
 Diarrhetic Shellfish Poisoning (DSP)

**Clinical Features**

**Y N Unk**

- Vomiting, diarrhea, and cramps within 24 hours of shellfish ingestion**  
   **Diarrhea (3 or more loose stools within a 24 hour period)**  
   Diarrhea or other gastrointestinal symptom within 0.5-36 hours of shellfish consumption  
   **Abdominal pain or cramps**  
   **Neurologic symptoms (e.g. paresthesia, ataxia, cranial nerve abnormalities, paralysis) within minutes to hours of shellfish consumption**  
   **Bulbar weakness (cranial nerve abnormalities)**  
   Ptosis (drooping eyelids)  
   Blurred or double vision  
   **Swallowing or speech difficulty**  
   **Dysphonia**  
   **Mouth tingling or numbness**  
   Paralysis or weakness  
   Ascending  
   Descending  
   Asymmetric  
   Symmetric  
   Acute  
   **Ataxia**  
   **Extremities numb**  
   **Excessive respiratory secretions**  
   Dyspnea (shortness of breath)  
   **Respiratory failure**  
   **Cardiac arrhythmias, ECG abnormalities**  
   **Confusion**  
   **Memory loss**  
   **Seizure new with disease**  
   **Coma**

**Hospitalization**

**Y N Unk**

Hospitalized at least overnight for this illness Facility name \_\_\_\_\_  
 Hospital admission date \_\_\_/\_\_\_/\_\_\_ Discharge \_\_\_/\_\_\_/\_\_\_ HRN \_\_\_\_\_  
 Disposition  Another acute care hospital Facility name \_\_\_\_\_  
 Died in hospital  
 Long term acute care facility Facility name \_\_\_\_\_  
 Long term care facility Facility name \_\_\_\_\_  
 Non-healthcare (home)  Unk  Other \_\_\_\_\_

Admitted to ICU Date admitted to ICU \_\_\_/\_\_\_/\_\_\_ Date discharged from ICU \_\_\_/\_\_\_/\_\_\_  
   Mechanical ventilation or intubation required  
   Still hospitalized As of \_\_\_/\_\_\_/\_\_\_

**Y N Unk**

Died of this illness Death date \_\_\_/\_\_\_/\_\_\_ *Please fill in the death date information on the Person Screen*  
   Autopsy performed  
   Death certificate lists disease as a cause of death or a significant contributing condition  
 Location of death  Outside of hospital (e.g., home or in transit to the hospital)  Emergency department (ED)  
 Inpatient ward  ICU  Other \_\_\_\_\_

**RISK AND RESPONSE (Ask about exposures .5-36 hours before symptom onset)**

**Travel**

	Setting 1	Setting 2	Setting 3
<b>Travel out of</b>	<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 sharing shellfish with similar symptoms or illness  
   **Bivalve shellfish (oysters, clams, mussels, etc.)** County of location collected \_\_\_\_\_  
 Type  Oysters  Clams  Geoducks  Mussels  Scallops  Cockles  Barnacles  
 Other \_\_\_\_\_

**Exposure and Transmission Summary**

**Y N Unk**

**Epidemiologic link to a confirmed human case**

**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

Describe \_\_\_\_\_

Suspected exposure setting  Day care/Childcare  School (not college)  Doctor's office  Hospital ward  Hospital ER  
 Hospital outpatient facility  Home  Work  College  Military  Correctional facility  Place of worship  
 Laboratory  Long term care facility  Homeless/shelter  International travel  Out of state travel  Transit  
 Social event  Large public gathering  Restaurant  Hotel/motel/hostel  Other \_\_\_\_\_

Describe \_\_\_\_\_

Exposure summary

**Public Health Issues**

Y N Unk

   Notify others sharing exposure**Public Health Interventions/Actions**

Y N Unk

   Commercial product implicated   Initiate trace-back investigation Source (business name, telephone, product) \_\_\_\_\_   Letter sent Date \_\_\_/\_\_\_/\_\_\_ Batch date \_\_\_/\_\_\_/\_\_\_   Any other public health action \_\_\_\_\_**NOTES****LAB RESULTS**Lab 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 document**Ordering Provider

WDRS ordering provider \_\_\_\_\_

Ordering facility

WDRS ordering facility name \_\_\_\_\_

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