**Administrative**

**Investigator**

**LHJ Case ID (optional)**

**LHJ notification date**

**Classification**
- Classification pending
- Confirmed
  - Not reportable
  - Probable
  - Ruled out
  - Suspect

**Investigation status**
- In progress
- Complete
- Complete – not reportable to DOH
- Unable to complete
- Reason

**Investigation start date**

**Investigation complete date**

**Case complete date**

**Outbreak related**
- Yes
- No

**LHJ Cluster ID**

**Cluster Name**

**Shellfish program notified**
- Yes
- No
- Date

**If not notified, reason**

### Communications

**Initial report source**

**LHJ**

**Reporter organization**

**Reporter name**

**Reporter phone**

**All reporting sources (list all that apply)**

- 
- 
- 

### Clinical Information

**Complainant ill**
- Yes
- No
- Unk

**Symptom Onset**

**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**
### Symptoms

- 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

- Hospitalized at least overnight for this illness
- Facility name _______________________________
- Hospital admission date ___/___/___
- Discharge ___/___/___
- HRN _____________________
- Disposition
  - Another acute care hospital
  - Died in hospital
  - Long term acute care facility
  - Long term care facility
  - Non-healthcare (home)
- Unk
- Other ____________________
- Mechanical ventilation or intubation required
- Admitted to ICU
- Date admitted to ICU ___/___/___
- Date discharged from ICU ___/___/___
- 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 ____________________
  - Y N Unk
  - Y N Unk

### Risk and Response

- Risk and Exposure Information
  - 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 ____________________
  - Y N Unk
  - Y N Unk

- Exposure and Transmission Summary
  - 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 ____________________
      - Y N Unk

Shellfish Poisoning required variables are in **bold**. Answers are: Yes, No, Unknown to case
## Exposure summary

### Public Health Issues
- **Y**  Notify others sharing exposure

### Public Health Interventions/Actions
- **Y**  Commercial product implicated
- **N**  Initiate trace-back investigation
- **Unk**  Source (business name, telephone, product) 
- **Y**  Letter sent
  - Date ___/___/___
  - Batch date ___/___/___
- **Unk**  Any other public health action

## NOTES

### LAB RESULTS

- **Lab report information**
- **Lab report reviewed** – LJH □
  - 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  □ Pending

- **Test 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** ___/___/___

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- **Ordering Provider** ____________________________
  - **WDRS ordering provider** ____________________________

- **Ordering facility** ____________________________
  - **WDRS ordering facility name** ____________________________