

**PATIENT IDENTIFIERS (Please tear off this page before sending the COVIS case report form to CDC. Patient identifiers should not be transmitted to CDC)**

Patient's Name:

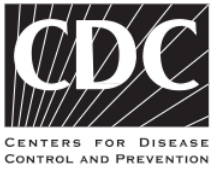
Patient's Address:

Telephone:

Physician's Name:

Telephone:

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# CHOLERA AND OTHER VIBRIO ILLNESS SURVEILLANCE REPORT

OMB 0920-0728 Exp. Date 01/31/2019

REPORTING HEALTH DEPARTMENT			SEND COMPLETED REPORT TO STATE INFECTION CONTROL State will forward to: covidresponse@cdc.gov E - fax : 404-235-1735 Centers for Disease Control and Prevention Enteric Diseases Epidemiology Branch 1600 Clifton Road, MS C09 Atlanta, GA 30333
State	City	County/Parish	
<input type="checkbox"/> <input type="checkbox"/>			

## 1. PATIENT CASE INFORMATION

1. First 3 letters of patient's last name: _____		2. Sex:    M        F        Unk	
3. Date of birth (MM/DD/YYYY): _____		4. Age: _____ <small>YEARS                      MONTHS</small>	3. NNDSS case ID
		4. Case state ID (required)	
5. Race:		6. Ethnicity:	
American Indian/Alaska Native      White Black or African American              Other Native Hawaiian or other Pacific      Unknown/not provided Islander                                      Asian		Hispanic/Latino Not Hispanic/Latino                      Unknown/not provided	
		7. Occupation: _____	

## 2. LABORATORY INFORMATION

Use the *Vibrio* Species key to indicate which species were positively identified by culture or CIDT result as applicable.

<u><i>Vibrio</i> Species Key:</u>	<i>V. cincinnatiensis</i> —CIN	<i>Grimontia hollisae</i> —HOL	<i>Vibrio</i> —species not identified—NID
<i>V. alginolyticus</i> —ALG	<i>Photobacterium damsela</i> subsp. <i>Damsela</i> —DAM	<i>V. metschnikovii</i> —MET	Other—OTH (Specify below)
<i>V. cholerae</i> O1—CH1	<i>V. fluvialis</i> —FLU	<i>V. mimicus</i> —MIM	Multiple species—MUL (Specify below)
<i>V. cholerae</i> O139—CH3	<i>V. furnissii</i> —FUR	<i>V. parahaemolyticus</i> —PAR	Epidemiologically linked to a laboratory detected case (no lab results)
<i>V. cholerae</i> non-O1, non-O139—CHN		<i>V. vulnificus</i> —VUL	

**Laboratory results (If more than one specimen is tested, complete one row per specimen. If more than two specimens were tested, please check here \_\_\_\_\_ and attach additional sheet. CIDT indicates a culture-independent diagnostic test.)**

1. <u>Specimen one:</u> Date collected: _____ (MM/DD/YY) Received at public health laboratory? Yes No Unk If yes, State lab ID: _____			
Specimen source:	Culture, result: Pos Neg Unk Not Done	CIDT, result: Pos Neg Unk Not Done	
Specimen Site:	If positive, species identified: _____	If positive, species identified: _____	
If Other, specify: _____	If species identified as multiple or other, specify: _____	Name/type of diagnostic test used: _____	
		If species identified as multiple or other, please specify: _____	

2. <u>Specimen two:</u> Date collected: _____ (MM/DD/YY) Received at public health laboratory? Yes No Unk If yes, State lab ID: _____			
Specimen Source:	Culture, result: Pos Neg Unk Not Done	CIDT, result: Pos Neg Unk Not Done	
Specimen Site:	If positive, species identified: _____	If positive, species identified: _____	
If Other, specify: _____	If species identified as multiple or other, specify: _____	Name/type of diagnostic test used: _____	
		If species identified as multiple or other, please specify: _____	

3. If other non-*Vibrio* organism(s) isolated from same specimen, list: \_\_\_\_\_

**Complete only if isolate is *Vibrio cholerae* O1 or O139:**

4. <u>Serotype:</u> Inaba        Ogawa	5. <u>BioType:</u> El Tor        Classical    Not done    Unk
Hikojima    Not done    Unk	6. <u>Toxigenic:</u> Yes        No        Not done    Unk

**3. CLINICAL INFORMATION**

1. Date illness began (MM/DD/YY): _____				4a. Admitted to a hospital overnight for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
2. Duration of illness (Days): _____				4b. If yes, admission date (MM/DD/YY): _____			
3a. Did patient die? Yes No Unknown				4c. Discharge date (MM/DD/YY): _____			
3b. If yes, date (MM/DD/YY): _____							
5. Did patient take an antibiotic as treatment for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
If yes, name(s) of antibiotic(s):			Date began antibiotic (MM/DD/YY):		Date ended antibiotic: (MM/DD/YY):		
1. _____			_____		_____		
2. _____			_____		_____		
3. _____			_____		_____		
<b>Signs and symptoms:</b>				<b>Medical history (optional for probable cases):</b>			
	Yes	No	Unk		Yes	No	Unk
Vomiting				Alcoholism			
Diarrhea				Diabetes			
Visible blood in stools				Gastric surgery			
Abdominal cramps				Heart disease (If yes, Heart failure? Y N U )			
Fever (>100.4F or 38 C)				Hematologic disease			
Muscle pain				Immunosuppressive condition/immunodeficiency			
Septic shock				Immunosuppressive therapy			
Cellulitis (Site _____)				Liver disease			
Bullae (Site _____)				Cancer			
Sequelae (e.g. amputation, skin graft) (Type: _____)				Kidney disease			
Other (ear pain, discharge, rash, etc.): _____				Took antacids or ulcer medication in past 30 days (Type/Frequency: _____)			
Additional signs and symptoms comments:				Peptic ulcer			
				Other: _____			
				If yes to any of the above conditions, specify type:			

**4. EPIDEMIOLOGY SECTION**

1. Was this case part of an outbreak? Yes No Unk		
2. If yes, please describe (include NORS ID if available): _____		
3. PulseNet cluster code (if available): _____		
4. Did patient travel outside their home state in the 7 days before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
5. Did patient travel to another country in the 7 days before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
6. If yes, list destinations and dates*:		
	Date arrived (MM/DD/YY)	Date left (MM/DD/YY)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

\*Please list any additional travel destinations or information in the comments section on page 5.

**Cholera exposure (Only complete if laboratory result includes toxigenic *V. cholerae* O1 or O139.)**

1. Was patient exposed to a person with cholera?  Yes  No  Unknown

2. If patient traveled outside of U.S., what was the reason for travel?  
 To visit relatives/friends      Tourism      Medical/Disaster Relief      Other: \_\_\_\_\_  
 Business      Military      Unknown

3. Has the patient ever received a cholera vaccine?    Yes    No    Unknown

4. If yes, most recent vaccination date (MM/DD/YYYY) : \_\_\_\_\_

**Seafood consumption**

**1. Only indicate consumption during the 7 days before illness began.**

<u>Type of Seafood</u>	Eaten?			Multiple dates?	Last date consumed (MM/ DD/ YY)	<u>Type of Seafood</u>	Eaten?			Multiple dates?	Last date consumed (MM/ DD/ YY)
	Y	N	U				Y	N	U		
Clams					_____	Shrimp					_____
Mussels					_____	Crawfish					_____
Oysters					_____	Lobster					_____
Scallops					_____	Crabs					_____
Other shellfish					_____	Fish					_____

Further description of seafood: \_\_\_\_\_

2. Did any dining partners consume the same seafood?    Yes    No    Unk    3. If yes, did any become ill?    Yes    No    Unk

**Water exposure**

**In the 7 days before illness began, was patient's skin exposed to any of the following?**

1a. A body of water (ocean, lake, etc.):    Yes    No    Unknown    1b. If yes, specify name of body of water: \_\_\_\_\_

1c. If exposed to water, indicate type:    Salt    Fresh    Brackish    Other, specify: \_\_\_\_\_    Unknown

2. Drippings from raw or live seafood, including handling/cleaning:    Yes    No    Unknown

3. Marine life, including stings/bites :    Yes    No    Unknown

4. Date of most recent exposure: (MM/DD/YY): \_\_\_\_\_

5. If yes to any of the above exposures, was this an occupational exposure?    Yes    No    Unknown

**6a. If patient's skin was exposed to any of the above, did patient sustain a wound or have a pre-existing wound?**  
 Yes, sustained a wound    Yes, had pre-existing wound    Yes, uncertain if old/new    No    Unknown

6b. If Yes, describe how wound occurred and site on body:  
 \_\_\_\_\_

Additional comments: \_\_\_\_\_ Lost to follow-up

Person completing section 1-4: \_\_\_\_\_ Date completed (MM/DD/YY): \_\_\_\_\_

Title/Agency: \_\_\_\_\_ Tel: \_\_\_\_\_

**5. SEAFOOD INVESTIGATION (Please complete one copy of this page for each type of seafood ingested and investigated, and identify investigation page number below. Completion of this page is optional for probable cases.)**

Seafood Investigation page \_\_\_\_ of \_\_\_\_

**Product information**

1. Type of seafood being investigated: \_\_\_\_\_ 2. Date consumed (MM/DD/YY): \_\_\_\_\_

3. Amount consumed (e.g., 6 oysters, 1 filet, 5oz, etc.): \_\_\_\_\_

4. How prepared: Fully cooked  Undercooked  Raw  Unknown

5. Additional relevant information on product preparation (e.g., specific variety of seafood consumed and plating): \_\_\_\_\_

6. Was this fish or shellfish harvested by the patient or a friend of the patient? Yes No  Unknown

(If yes, skip to source information questions. If no, complete entire page as possible.)

**Commercial vendor Information (only complete if product consumed at a commercial establishment)**

1. Name of restaurant, oyster bar, or food store: \_\_\_\_\_

Address: \_\_\_\_\_ Tel: \_\_\_\_\_

City/State: \_\_\_\_\_

2. Type of establishment:  Oyster bar or restaurant  Seafood market  Unknown  
 Truck or roadside vendor  Other (specify): \_\_\_\_\_  
 Food store \_\_\_\_\_

3. Date restaurant or food outlet received seafood (MM/DD/YY): \_\_\_\_\_

4. Was the seafood imported from another country?  Yes  No  Unknown

If yes, name of country: \_\_\_\_\_

5. Was a restaurant or outlet environmental assessment conducted?  Yes  No  Unknown6. Was there evidence of improper handling or storage?  Yes  No  Unknown

If yes (check all that apply): Holding temperature violation Cross-contamination Co-mingling of live and dead shellfish

 Improper storage  Other: \_\_\_\_\_

7. If oysters, clams, or mussels were eaten, how were they received by the retail outlet?

 Live shellstock  Processed animal with shell attached  Shucked meat  Unknown  Other (specify): \_\_\_\_\_**Source information**1. Were seafood tags, invoices, or labels available?  Yes  No  Unknown (If yes, please attach to form)2. List shippers and associated certification numbers if on tags:  
\_\_\_\_\_

3. If harvest areas are known:

Harvest area classification (if known):

Area 1:	Date :	Approved Conditionally restricted Restricted	Conditionally approved Prohibited	Product harvested:	Harvest State:
_____	_____ (MM/DD/YY)			_____	_____
Area 2:	Date :	Approved Conditionally restricted Restricted	Conditionally approved Prohibited	Product harvested:	Harvest State:
_____	_____ (MM/DD/YY)			_____	_____

 Check if additional harvest area page is attached

Person completing section 5:

Date completed (MM/DD/YY):

Title/Agency:

Tel:

**Additional harvest area page**

Harvest areas:		Harvest area classification (if known):			
Area 3: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____
Area 4: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____
Area 5: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____
Area 6: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____
Area 7: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____
Area 8: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____
Area 9: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____
Area 10: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____

**Additional laboratory results (If more than one specimen is tested, complete one row per specimen)**  
 \*CIDT indicates Culture-Independent Diagnostic Test

3. Specimen three: Date collected: \_\_\_\_\_ (MM/DD/YY) Received at public health laboratory?  Yes  No  Unk If yes, State lab ID: \_\_\_\_\_

Specimen source: _____	<u>Culture</u> , result: Pos Neg Unk Not Done If positive, species identified: _____	<u>CIDT</u> , result: Pos Neg Unk Not Done If positive, species identified: _____
Specimen Site: _____	If species identified as multiple or other, specify: _____	Name/type of diagnostic test used: _____
If Other, specify: _____	If species identified as multiple or other, specify: _____	If species identified as multiple or other, please specify: _____

4. Specimen four: Date collected: \_\_\_\_\_ (MM/DD/YY) Received at public health laboratory?  Yes  No  Unk If yes, State lab ID: \_\_\_\_\_

Specimen source: _____	<u>Culture</u> , result: Pos Neg Unk Not Done If positive, species identified: _____	<u>CIDT</u> , result: Pos Neg Unk Not Done If positive, species identified: _____
Specimen Site: _____	If species identified as multiple or other, specify: _____	Name/type of diagnostic test used: _____
If Other, specify: _____	If species identified as multiple or other, specify: _____	If species identified as multiple or other, please specify: _____