

Cholera

Agency: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case

Reviewer initials: _____
Referred to another state: _____

Investigator: _____

Phone number: _____

CASE

Last name: _____
First and middle name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____

Gender: Female Male Other _____

Maiden name: _____ Suffix: _____

Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____

Marital status: Single Married Divorced Parent with partner Separated Widowed

Address line: _____

Zip: _____ City: _____

Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian

State: _____ County: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Phone: (____) - ____ - ____ Type: _____
Long-term care resident: Yes No Unknown

Parent/Guardian name: _____

Facility name: _____

Parent/Guardian phone: (____) - ____ - ____ Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____

Event outcome: Survived this illness Died from this illness
 Died unrelated to this illness Unknown

Outbreak related: Yes No Unknown

Outbreak name: _____

Exposure setting: _____

Epi-linked: Yes No Unknown

Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown

State: _____ Country: _____

Healthcare provider information

Last name: _____

First name: _____

Provider title: ARNP MD DO NP PA

Facility name: _____

Address line 1: _____

Address line 2: _____

Zip code: _____ City: _____

State: _____ County: _____

Phone : (____) - ____ - ____ Type: _____

LABORATORY FINDINGS

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____

Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative

Organism: _____ Type (e.g. serogroup): _____ Other _____

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____

Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative

Organism: _____ Type (e.g. serogroup): _____ Other _____

Laboratory: _____ Accession #: _____ Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____ Specimen source: _____ Test type: _____

Result type: Preliminary Final Result date: ____ / ____ / ____ Result: Positive Negative

Organism: _____ Type (e.g. serogroup): _____ Other _____

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date worked from: ____/____/____ Date worked to: ____/____/____ Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date removed: ____/____/____ Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Job title: _____ Facility name: _____ Address: _____ Zip code: _____ City: _____ State: _____ County: _____ Phone: (____)____-____-____ Type: _____ Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Health care worker type: _____
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HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Isolated at entry: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Isolation type (entry): _____
Admission date: ____/____/____	Discharge date: ____/____/____	Days hospitalized: _____
Currently isolated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: _____	

INFECTION TIMELINE



CLINICAL INFO & DIAGNOSIS

- Symptoms** Abdominal cramps Headache Nausea Visible bloody diarrhea Watery diarrhea
 Diarrhea Muscle pain Shock Vomiting

In the 30 days prior to onset, were any of the following treatments received:

Antibiotics? Yes No Unknown

If Yes, complete the following table:

Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____
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Chemotherapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Type: _____	Immuno-suppressant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Type: _____
Radiation therapy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Type: _____	Antacid: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Type: _____
Systemic steroid: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Type: _____	Ulcer medication: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Type: _____

TREATMENT

Antibiotics prescribed? Yes No Unknown

Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ a day: _____ Route: _____	Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ a day: _____ Route: _____	Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ a day: _____ Route: _____
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RISK FACTORS/TRAVEL

Vaccinated for cholera? Yes No Unknown

Date vaccinated: ____/____/____ Lot #: _____ Vaccine type: _____ Manufacturer: _____	Date vaccinated: ____/____/____ Lot #: _____ Vaccine type: _____ Manufacturer: _____	Date vaccinated: ____/____/____ Lot #: _____ Vaccine type: _____ Manufacturer: _____
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Number of vaccinations: _____

In the 7 days prior to the onset of the symptoms has the case:
 Traveled outside U.S.? Yes No Unk Country: _____
 Departure date: ____/____/____ Return date: ____/____/____

Other Exposures	Raw/partially cooked seafood consumed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Source/ type: _____ Brand name: _____ From date consumed: ____/____/____ To date consumed: ____/____/____
	Street vendor food consumed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Vendor name: _____ Address: _____ Zip: _____ City: _____ State: _____ County: _____ Phone: _____ Type: _____

Worked with a Case: Yes No Unk From date: ____/____/____ To date: ____/____/____
 Lived with another Case: Yes No Unk From date: ____/____/____ To date: ____/____/____

Went Swimming? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Facility name: _____ Address: _____ County: _____	Water type: _____ From date swam: ____/____/____ Zip: _____ City: _____ State: _____ Phone: _____	Location type: _____ To date swam: ____/____/____ Type: _____
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CONTACTS

Number of people living in case's household: _____ Close contacts with the case and/or same exposures? Yes No Unknown

Close contacts of case or close contacts with same exposures

Name	DOB	Gender	Address/Phone
_____	____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____
Relationship to case		List symptoms	Symptom onset date Is contact a case?

<input type="checkbox"/> Spouse	<input type="checkbox"/> Sexual contact		<input type="checkbox"/> Yes
<input type="checkbox"/> Child	<input type="checkbox"/> Family member (non-household) _____ / /		<input type="checkbox"/> No
<input type="checkbox"/> Sibling	<input type="checkbox"/> Friend/acquaintance _____		
<input type="checkbox"/> Roommate	<input type="checkbox"/> Contact- work/school/etc _____		
<input type="checkbox"/> Parent/ guardian	<input type="checkbox"/> Unknown/Other _____		

If this contact is a case create a new event and/or case for this contact. ←

Name	DOB	Gender	Address/Phone
_____ / /		<input type="checkbox"/> Male <input type="checkbox"/> Female	_____
		Zip code: _____	Phone: - -
Relationship to case	List symptoms	Symptom onset date	Is contact a case?
<input type="checkbox"/> Spouse	<input type="checkbox"/> Sexual contact		<input type="checkbox"/> Yes
<input type="checkbox"/> Child	<input type="checkbox"/> Family member (non-household) _____ / /		<input type="checkbox"/> No
<input type="checkbox"/> Sibling	<input type="checkbox"/> Friend/acquaintance _____		
<input type="checkbox"/> Roommate	<input type="checkbox"/> Contact- work/school/etc _____		
<input type="checkbox"/> Parent/ guardian	<input type="checkbox"/> Unknown/Other _____		

If this contact is a case create a new event and/or case for this contact. ←

Name	DOB	Gender	Address/Phone
_____ / /		<input type="checkbox"/> Male <input type="checkbox"/> Female	_____
		Zip code: _____	Phone: - -
Relationship to case	List symptoms	Symptom onset date	Is contact a case?
<input type="checkbox"/> Spouse	<input type="checkbox"/> Sexual contact		<input type="checkbox"/> Yes
<input type="checkbox"/> Child	<input type="checkbox"/> Family member (non-household) _____ / /		<input type="checkbox"/> No
<input type="checkbox"/> Sibling	<input type="checkbox"/> Friend/acquaintance _____		
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Name	DOB	Gender	Address/Phone
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<input type="checkbox"/> Child	<input type="checkbox"/> Family member (non-household) _____ / /		<input type="checkbox"/> No
<input type="checkbox"/> Sibling	<input type="checkbox"/> Friend/acquaintance _____		
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<input type="checkbox"/> Parent/ guardian	<input type="checkbox"/> Unknown/Other _____		

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NOTES:
