

CYCLOSPORIASIS SURVEILLANCE CASE REPORT FORM

Form Approved
OMB NO. 0920-0009

Demographic Data:

Patient's name: Last First

State of residence: County:

Sex: Male Female Age: Date of birth (mm/dd/yy):

Race/Ethnicity (select one or more):

- American Indian or Alaska Native
Black or African American
Native Hawaiian or Other Pacific Islander
Asian
Hispanic or Latino
White
Unknown

Physician's Name: Phone:
Physician's Email:

Clinical Data: (NOTE: for dates, be as specific as possible. However, approximations (e.g., mm/yy) are okay.)

Date of illness onset (mm/dd/yy): Unknown

Signs and symptoms:

Diarrhea: Yes No Unknown Fatigue: Yes No Unknown
Maximum number stools per day: (unknown = 999)
Anorexia: Yes No Unknown
Nausea: Yes No Unknown
Weight loss: Yes No Unknown Vomiting: Yes No Unknown
Baseline weight: lbs. (unknown = 999) Abdominal cramps: Yes No Unknown
Number of pounds lost: Other symptoms (specify):
Fever: Yes No Unknown
Temperature (if measured): degrees F (unknown = 999)
Hospitalized (at least overnight): Yes No Unknown
If yes, list name of hospital: Date of admission:

Stool collection date: Results: Positive Negative Unknown

Confirmed by state lab? Yes No Unknown Confirmed by CDC lab? Yes No Unknown

Was the case-patient treated for cyclosporiasis? Yes No Unknown

If yes, what medication was provided? trimethoprim/sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)
Other (specify): Unknown

Is case-patient sulfa-allergic? Yes No Unknown

Epidemiologic Data: (NOTE: for dates, be as specific as possible. However, approximations (e.g., mm/yy) are okay.)

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).

Name (person filling out form): _____

Title: _____

Phone: _____ - _____ - _____ FAX: _____ - _____ - _____

Email: _____

Name of investigating health department: _____

Date form completed: ____/____/____

Revised 9/3/02