

Attachment 3 0920 0004 Change Request 9 22 08

Screen shots of Data Collection Instrument

OMB No.: 0920-0004
Expiration: 10/2010

Public reporting burden for this collection of information is estimated to average 8 hours 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 Information Collection Review Office; 1600 Clifton Road NE, M.S. D-74; Atlanta, Ga. 30333; ATTN: Paperwork Reduction Act Project (0920-0004)

HAB Human Illness Report 1.3 - Windows Internet Explorer provided by CDC - Unauthorized Use Prohibited



HABs

Harmful Algal Blooms

Human Illness Report

The human illness report collects the results for enhanced surveillance of human illness, potentially associated with exposure to algal toxins. The data collected on the following pages will help determine the burden of harmful algal bloom (HAB) illness.

Please follow the screen prompts, and provide accurate and timely data. If you need assistance with a human illness report or you would like to conduct a test run, please contact Rebecca LePrell at rlprell@cdc.gov.

Year(4Digit)	Auto Report Number
<input type="text" value="1950"/>	078
State Code	Resulting Report ID
<input type="text" value="HAB, Georgia - GA"/>	{ 9/28/2007 10:23:58 AM }
State ID (if applicable)	
<input type="text"/>	

<< Previous < Go > **Print** **Close** **Cancel** **Next >>**


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HABs

Harmful Algal Blooms



State/County Agency or Other point of contact

Name of Agency

Type of Agency

Name of Caller

Address of Caller

Phone Number of Caller

E-mail address

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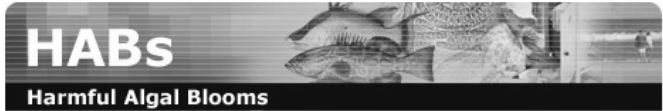
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Identifying information about the case

Name of patient (last, first)

Home address of case:

Street No.
Street:
City:
County:
State:
Zip:

Contact Information:

Phone:
Cell:
Beeper:
Work:
Other:
E-mail:

Other contact information:

Occupation:

- Waterman/ Fisherman/ Harvester
- Field personnel
- Environmental personnel
- Aquatic pesticide applicator
- Lifeguard
- Landscape worker
- Other:

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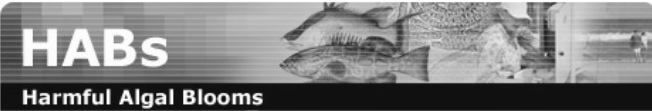
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HABs

Harmful Algal Blooms

Module 3: Case Demographics

Date of Birth: {mm/dd/yyyy}

Age (in years):

Sex:

Male
 Female
 Refused
 Don't Know

With which racial group do you most closely identify?

1. American Indian/Alaska Native
 2. Asian
 3. Black or African American
 4. Native Hawaiian/other Pacific Islander
 5. White
 6. Don't know
 7. Refused

Are you of Hispanic origin?

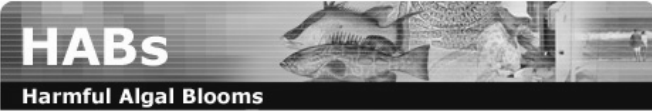
Yes
 No
 Refused
 Don't know

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Harmful Algal Blooms

Exposure information

Date of exposure: {mm/dd/yyyy}

Time of exposure: :

Activity at time of exposure?

Occupational
 Recreational
 Unknown

If water or air, duration of exposure:

Water

Air

Route of exposure (check all that apply):

Inhalation
 Dermal contact
 Ingestion
 Unknown
 Other

Possible/potential source(s) (check all that apply):

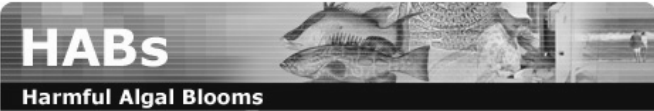
Food
 Brackish water
 Sea water
 Fresh water
 Drinking water
 Air
 Other type of exposure (describe):

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HABs

Harmful Algal Blooms

Food

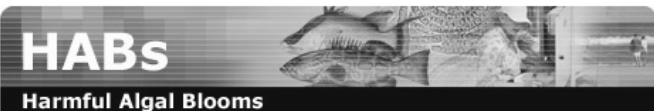
<p>If food:</p> <p><input type="checkbox"/> Shellfish (mussels, scallops, clams, oysters, etc)</p> <p><input type="checkbox"/> Finfish (cod, grouper, bass, trout, salmon, etc)</p> <p><input type="checkbox"/> Lobster / Crab / Shrimp</p> <p><input type="checkbox"/> Other:</p> <div style="border: 1px solid black; width: 100px; height: 15px; margin-left: 20px;"></div>	<p>How was the food prepared?</p> <p><input type="checkbox"/> Cooked</p> <p><input type="checkbox"/> Raw</p> <p><input type="checkbox"/> Unknown</p>
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Harmful Algal Blooms

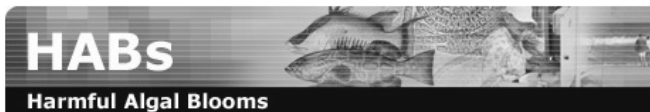
Dermal Contact

<p>Areas of contact with water</p> <p><input type="checkbox"/> Arms</p> <p><input type="checkbox"/> Face</p> <p><input type="checkbox"/> Feet</p> <p><input type="checkbox"/> Hands</p> <p><input type="checkbox"/> Legs</p> <p><input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Trunk</p> <p><input type="checkbox"/> Don't Know</p>	<p>Were there puncture wounds in exposed area?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Don't know</p>
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Patient Reported Environmental Conditions

Report of environmental conditions during exposure:

Dead fish count species
 Sick fish count species (Enter "Unknown" if unknown species)
 Other dead and sick animals count species
 Unknown

Did patient note any unusual odors or smells during exposure?

Yes describe
 No
 Don't know

Patient report of other exposed people:

Please add any exposed persons below.

Was water... (check appropriate)

Moving
 Stagnant
 Unknown

Water Color Water Clarity

Scum observed?

Yes
 No
 Don't Know

Tide... (check appropriate)

High tide
 Low tide
 Flood tide (incoming)
 Ebb tide (outgoing)
 Unknown
 Slack tide
 Not applicable

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Signs and Symptoms

• First presentation of symptom(s):

Date: : : :

What symptoms did patient first experience?

What is patient's chief complaint?

GENERAL * Onset is from time of first exposure event * Duration is from time of onset

<input type="checkbox"/> Fatigue	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Fever	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Malaise	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Anorexia	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>

HEENT

<input type="checkbox"/> Earache	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Headache	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Conjunctivitis	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Nasal Congestion/ Rhinitis	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Sore or Irritated Throat	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Other:	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>

RESPIRATORY

<input type="checkbox"/> Cough	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Shortness of Breath	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Wheezing/attack	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Chest tightness	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Other:	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>

CARDIOVASCULAR

<input type="checkbox"/> Chest pain	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Irregular heart rhythm	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Pale extremities	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Cyanosis of extremities	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Other:	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>

GASTROINTESTINAL

<input type="checkbox"/> Nausea	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Vomiting	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Diarrhea	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/>	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>

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MUSCULOSKELETAL

<input type="checkbox"/> Muscle Pain	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Joint Pain	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Other: <input type="text"/>	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>

NEUROLOGIC

<input type="checkbox"/> Confusion	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Memory Loss	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Seizure	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Coma	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Numbness	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Weakness	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Paralysis	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Lightheadedness/ Sensation of floating	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Vertigo/ Sensation of spinning	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Hot/ Cold Sensation reversal	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Tingling of lips / tongue/ throat	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Tingling of extremities	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Other <input type="text"/>	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>

DERMATOLOGIC

<input type="checkbox"/> Itching	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Tingling / Burning	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Other: <input type="text"/>	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>
<input type="checkbox"/> Rash (please fill in info below)	Onset	<input type="text"/>	Duration	<input type="text"/>	Episodic	<input type="text"/>

Description of rash:

If rash, indicate the location:

- Left Hand
- Right Hand
- Left Leg
- Right Leg
- Face
- Neck

Did patient report multiple exposures?

- Yes
- No
- Don't Know

If yes, did symptoms recur?

- Yes
- No
- Don't know

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Medical Information : Patient Interview

Was this patient interviewed? Yes
 No
 Don't Know

Do you presently have, or anyone in your family had a cold or the flu in the past two weeks?

- Yes
- No
- Don't know

Have you smoked more than 100 cigarettes in your lifetime?

- Yes
- No
- Don't know

Do you currently smoke?

- Yes
- No
- Don't know

Are you currently pregnant or breastfeeding?

- Yes, I am pregnant
- Yes, I am nursing
- No
- Don't Know

If yes, how many packs per year

Do you drink alcohol?

- Yes
- No
- Don't know

If yes, did you drink within 24 hours prior to onset of symptoms?

- Yes
- No
- Don't know

Did you take any new medications in the month before onset of symptoms?

- Yes If yes
- No
- Don't know

Did you take any dietary supplements in the month before onset of symptoms?

- Yes If yes
- No
- Don't know

Has there been a review of the patient's medical records?

- Yes
- No
- Don't know

Does the patient have any pre-existing medical conditions? Yes
 No
 Don't know

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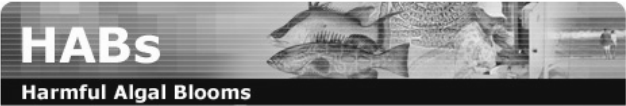
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Patient Information: Chart Review

HCP identifying information

Name:
Street:
City:
State: Same as before
Zip:
Phone:
Specialty:

Was patient hospitalized? Yes No Don't Know
Name of Hospital:
Street:
City:
County:
Date of admission:
State:
Zip:

Has the patient had contact with anyone with similar symptoms in the past two weeks?

Yes
 No
 Don't know

If patient was hospitalized, what is their current disposition? Released Still hospitalized Dead Unknown
Date of release:

Were any lab tests conducted? If no, skip to next page.
 Yes
 No (skip to next section)
 Don't know

TEST RESULTS

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TEST RESULTS

SKIN BIOPSIES

Were any skin biopsies conducted?

- Yes , explain
- No (skip to next section)
- Don't know

FECAL SMEARS

Where any fecal smears performed?

- Yes
- No
- Don't Know

Bacterial

- Not performed
- No organisms seen
- gram + bacilli
- gram - bacilli
- gram + cocci
- gram - cocci
- spirochete (dark field microscopy)
- Other (specify):

Fungal

- Not performed
- No organisms seen
- KOH +
- KOH -
- Other (specify):

Mycobacterial (AFB)

- Not performed
- No organisms seen
- acid fast +
- acid fast -
- Other (specify):

Was PARASITOLOGY performed?

- Yes, but no organisms present
- Yes, organisms were present but not identified
- Yes, organisms identified
- No
- Don't Know
- Other

(Test1)

- Ova and parasite +
- Ova and parasite -

(Test2)

- Ova and parasite +
- Ova and parasite -

(Test3)

- Ova and parasite +
- Ova and parasite -

Was HISTOPATHOLOGY performed?

- Yes Tissue
- No
- Don't Know

Findings

- Normal
- Neoplastic cells
- Inflammatory Reaction

Neoplastic cells

Inflammatory reaction

CULTURES

Where any cultures taken?

- Yes
- No
- Don't Know

Bacterial

- Not performed
- No organisms seen
- gram + bacilli
- gram - bacilli

Fungal

- Not performed
- No organisms seen
- KOH +
- KOH -

Mycobacterial (AFB)

- Not performed
- No organisms seen
- KOH +
- KOH -

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X-RAYS

Were any X-rays taken? Yes
 No (skip to next section)
 Don't know

Date	Date	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Type of X-ray	Type of X-ray	Type of X-ray
<input type="radio"/> Chest <input type="radio"/> Other: <input type="radio"/> Unknown	<input type="radio"/> Chest <input type="radio"/> Other: <input type="radio"/> Unknown	<input type="radio"/> Chest <input type="radio"/> Other: <input type="radio"/> Unknown
<input type="text"/>	<input type="text"/>	<input type="text"/>
Results	Results	Results
<input type="radio"/> Normal <input type="radio"/> Abnormal (explain):	<input type="radio"/> Normal <input type="radio"/> Abnormal (explain):	<input type="radio"/> Normal <input type="radio"/> Abnormal (explain):
<input type="text"/>	<input type="text"/>	<input type="text"/>

BLOOD TESTS

Were any blood tests performed?
 Yes
 No (skip this section)
 Don't Know

Liver Enzyme Concentrations section

AST (U/L)

ALT (U/L)

Microcystin ($\mu\text{g/L}$)

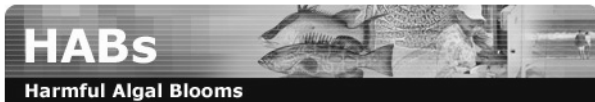
Renal Enzymes

Creatinine (mg/dL)

BUN

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Assessment and Follow-Up

Status

Complete

Follow-up required

Is follow-up being done?

- Yes
- No
- Don't know

Date of action: {mm/dd/yyyy}

If yes, what is being done (describe):

FINAL ASSESSMENT

Diagnosis: (check one)

- Not a HAB-related illness case
- Not likely HAB-related illness
- Possible HAB-related illness [Confirmed exposure to water with confirmed algal bloom AND onset of associated signs and symptoms within a reasonable time after exposure AND excludes other causes of signs and symptoms]
- Probable HAB-related illness [Meets criteria for "possible case" AND there is laboratory documentation of HAB toxin in water.]
- Confirmed HAB-related illness [Meets criteria for "probable case" AND there is documentation of HAB toxin in a clinical specimen taken from the case subject or meal remnant.]

Other cause not HAB-related

- Yes
- No

If not HAB-related, what is the diagnosis:

Disposition / Comments / Notes

Items to follow-up on

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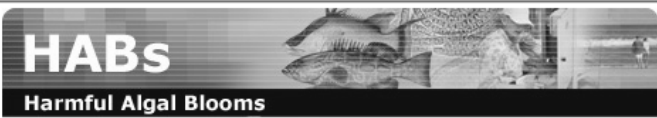
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Cancel

Save and Close

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Algal Bloom Report

An Algal Bloom Report contains, on the following pages, environmental data about a particular bloom in your state.

Site Code	Approximate Start Date	Site Name	Name of Water Body
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Resulting Report ID	Bloom ID Number	State Code	Bloom
{ 10/19/2007 9:43:03 AM }	216	HAB, Washington - WA	<input type="text"/>

Continue to the next page to view or enter environmental data about this bloom. You may also view or enter any illness data associated with the bloom. The fields provided below link directly to the Human and Animal Illness reports, thought to be associated with this particular bloom.

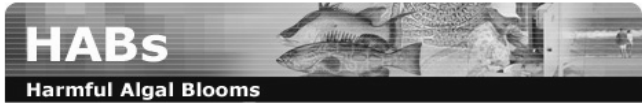
Human Illness Reports

Create Link

Animal Illness Reports

Create Link

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PART 1: WATER SAMPLE INFORMATION

Was a water sample collected for the purpose of identifying organisms?

- Yes
- No

Date of sample collection

Time of sample collection

 : :

Type of sample collected

Water sample collected for:

- Monitoring
- Event Response
- Other:

Was water...

- Moving
- Stagnant
- Unknown

Type of water:

- Fresh
- Brackish
- Salt
- Don't Know

Fecal coliforms tested

- Yes
- No
- Don't Know

Fecal coliforms detected

- Yes
- No

If yes, what organism (i.e., Enterococci, E. coli):

Counts:

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Water Appearance

Color Clarity Scum observed?
 Yes
 No
 Don't Know

Location of sample collection

LATITUDE / LONGITUDE
Lat: Start
Long: City:
County:
River mile marker/tributary:
Zip:

Sample Collector

Agency name:
City:
Zip:
Phone:

Lab providing identification

Lab name:
 Federal
 State
 County
 Other (Private):

Water quality parameters

Nitrate-Nitrite (mg/L as Nitrogen)
Total Phosphorus (mg/L as P)
Total Kjeldahl Nitrogen (TKN)
Ammonium (mg/L as Nitrogen)
Chlorophyll a (ug/L)
Dissolved oxygen (mg/L)
pH
Conductivity (uS/cm)
Water temperature (°C)
Secchi disk values
Salinity(ppt)
Turbidity(ntu)
Silicate
Urea
Total Suspended Solids
Extinction Co-efficient (per meter)

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Harmful Algal Blooms

PART 2: TOXIN IDENTIFICATION

Test for Toxicity performed?

- Yes
- No
- Unknown

Toxin(s):

- Anatoxin
- Azaspiracid
- Brevetoxins
- Brevetoxin-like
- Brevetoxin PbTx-1
- Brevetoxin PbTx-2
- Brevetoxin PbTx-3
- Ciguatoxins
- Cylindrospermopsin
- Ciguatoxin
- Domoic acid
- Dinophysistoxin-1
- Homoanatoxin-a
- Haemolytic toxin
- Karlotoxin
- Karlotoxin prymnesi
- Lyngbyatoxin-a
- Microcystin Total
- Microcystin LR
- Maitotoxin
- Nodularin
- Okadaic acid
- Pectenotoxin-2
- Prymnesin
- Saxitoxins
- Unidentified toxin
- Other Identified toxin

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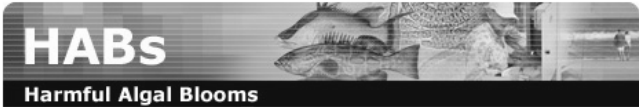
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HABs

Harmful Algal Blooms

Brevetoxins

Laboratory Name	<input type="text"/>	Method	Value
Phone Number	<input type="text"/>	<input type="radio"/> ELISA	<input type="text"/> <input type="button" value="v"/>
Sample ID	<input type="text"/>	<input type="radio"/> LC	<input type="text"/> <input type="button" value="v"/>
		<input type="radio"/> LC-MS	<input type="text"/> <input type="button" value="v"/>
		<input type="radio"/> GC-MS	<input type="text"/> <input type="button" value="v"/>
		<input type="radio"/> Other	<input type="text"/> <input type="button" value="v"/>
		<input type="text"/>	<input type="text"/> <input type="button" value="v"/>

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HABs

Harmful Algal Blooms

Thank you for creating a Harmful Algal Bloom Report.

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