

PATIENT'S NAME:	TEL.: Home _____ Work _____
ADDRESS:	
PHYSICIAN'S NAME:	TEL.:

- PATIENT IDENTIFIERS NOT TRANSMITTED TO CDC

SEND COMPLETED REPORT TO STATE INFECTION CONTROL
 State will forward to: Centers for Disease Control and Prevention
 Enteric Diseases Epidemiology Branch
 1600 Clifton Road, MS A38
 Atlanta, GA 30333
 Fax 404-639-2205
 OMB 0920-0004 Exp. Date 06/30/2010



CHOLERA AND OTHER VIBRIO ILLNESS SURVEILLANCE REPORT

I. DEMOGRAPHIC AND ISOLATE INFORMATION

1. First three letters of patient's last name: <input type="text"/> <input type="text"/> <input type="text"/> (1-3)	REPORTING HEALTH DEPARTMENT		
	State: <input type="text"/> <input type="text"/> (4-5)	City: (6-15)	County/Parish: (16-26)
	State Epi No.: (27-37)	State Lab ID: (38-49)	CDC USE ONLY <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (50-60)

2. Date of birth:	3. Age:	4. Sex: (80)	5. Ethnicity: (81)	6. Race: (70)	7. Occupation: (71-81)
Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/> (70-75)	Years <input type="text"/> Mos. <input type="text"/> (76-79)	M (1) F (2) Unk. (9)	Hispanic or Latino Origin? Yes (1) Unk (9) No (2)	Black or African American (2) American Indian/Alaska Native (5) Asian (4) Native Hawaiian or other Pacific Islander (6) White (1) Unk. (9)	

8. Vibrio species isolated (check one or more):				Date specimen collected				
Species	Source of specimen(s) collected from patient (If more than one specify earliest date)				Date specimen collected			If wound or other, specify site :
	Stool	Blood	Wound	Other	Mo.	Day	Yr.	
<i>V. alginolyticus</i>				(85)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(86-91) _____ (92-103)
<i>V. cholerae</i> O1				(107)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(108-113) _____ (114-125)
<i>V. cholerae</i> O139				(129)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(130-135) _____ (136-147)
<i>V. cholerae non-O1, non-O139</i>				(151)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(152-157) _____ (158-169)
<i>V. cincinnatiensis</i>				(173)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(174-179) _____ (180-191)
<i>V. damsela</i>				(195)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(196-201) _____ (202-213)
<i>V. fluvialis</i>				(217)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(218-223) _____ (224-235)
<i>V. furnissii</i>				(239)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(240-245) _____ (246-257)
<i>V. hollisae</i>				(261)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(262-267) _____ (268-279)
<i>V. metschnikovii</i>				(283)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(284-289) _____ (290-301)
<i>V. mimicus</i>				(305)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(306-311) _____ (312-323)
<i>V. parahaemolyticus</i>				(327)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(328-333) _____ (334-345)
<i>V. vulnificus</i>				(349)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(350-355) _____ (356-367)
<i>Vibrio</i> species - not identified				(371)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(372-377) _____ (378-389)
Other (specify): _____ (390-405)				(409)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(410-415) _____ (416-427)

9. Were other organisms isolated from the same specimen that yielded Vibrio? Yes (1) No (2) Unk. (9) (428) Specify organism(s): _____ (429-450)	10. Was the identification of the species of Vibrio (e.g., vulnificus, fluvialis) confirmed at the State Public Health Laboratory? Yes (1) No (2) Unk. (9) (451)
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11. Complete the following information if the isolate is Vibrio cholerae O1 or O139:		
Serotype (452) (check one) Inaba (1) Not Done (4) Ogawa (2) Unk. (9) Hikojima (3)	Biotype (453) (check one) El Tor (1) Not Done (3) Classical (2) Unk. (9)	Toxicogenic? (454) (check one) If YES, toxin positive by: (check all, that apply) Yes (1) No (2) Unk. (9) ELISA (455) Latex agglutination (456) Other (specify): _____ (457-471)

Name of Hospital: _____

Address: _____

State: Age: Sex:

II. CLINICAL INFORMATION

Vibrio species: _____

1. Date and time of onset of first symptoms:

Mo.	Day	Yr.
<input type="text"/>	<input type="text"/>	<input type="text"/>

(472-7)

Hour	Min.	am (1)	pm (2)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

(478-9) (480-1) (482)

2. Symptoms and signs:

	max.	Yes (1)	No (2)	Unk. (9)	Yes (1)	No (2)	Unk. (9)
Fever	temp. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	F (1)	C (2)				
Nausea				(489)	Headache		(497)
Vomiting				(490)	Muscle pain		(498)
Diarrhea	(max. no. stools/24 hours: <input type="text"/>) (493-494)			(491)	Cellulitis		(499) Site: _____ (500-514)
Visible blood in stools				(492)	Bullae		(515) Site: _____ (516-530)
Abdominal cramps				(495)	Shock (systolic BP <90)		(531)
				(496)	Other		(532) (specify): _____ (533-549)

3. Total duration of illness:

(days) (550-552)

4. Admitted to a hospital for this illness? (553)

Yes (1)	Admission date: Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>	(554-559)
No (2)	Discharge date: Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>	(560-565)
Unk. (9)		

5. Any sequelae? (e.g., amputation, skin graft) (566)

If YES, describe:

Yes (1)	_____
No (2)	_____
Unk. (9)	_____ (567-635)

6. Did patient die? (636)

Yes (1)	If YES, date of death: Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>	
No (2)		
Unk. (9)		(637-642)

7. Did patient take an antibiotic as treatment for this illness? (643)

If YES, name(s) of antibiotic(s):

Yes (1) No (2) Unk. (9)

	Date began antibiotic:			Date ended antibiotic:		
	Mo.	Day	Yr.	Mo.	Day	Yr.
1. _____ (644-646)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. _____ (659-661)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. _____ (674-676)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

8. Pre-existing conditions?

Yes (1) No (2) Unk. (9)

Alcoholism	(689)	Yes (1)	No (2)	Unk. (9)
Diabetes	(690) on insulin?			(691)
Peptic ulcer	(692)			
Gastric surgery	(693) type: _____ (694-709)			
Heart disease	(710) Heart failure?			(711)
Hematologic disease	(712) type: _____ (713-728)			
Immunodeficiency	(729) type: _____ (730-745)			
Liver disease	(746) type: _____ (747-762)			
Malignancy	(763) type: _____ (764-779)			
Renal disease	(780) type: _____ (781-796)			
Other	(797) specify: _____ (798-810)			

9. Was the patient receiving any of the following treatments or taking any of the following medications in the 30 days before this Vibrio illness began?

Yes (1) No (2) Unk. (9) If YES, specify treatment and dates:

Antibiotics	(811) _____ (812-830)
Chemotherapy	(831) _____ (832-850)
Radiotherapy	(851) _____ (852-870)
Systemic steroids	(871) _____ (872-890)
Immunosuppressants	(891) _____ (892-910)
Antacids	(911) _____ (912-930)
H ₂ -Blocker or other ulcer medication (e.g., Tagamet, Zantac, Omeprazole)	(931) _____ (932-950)

III. EPIDEMIOLOGIC INFORMATION

1. Did this case occur as part of an outbreak? (Two or more cases of Vibrio infection) Yes (1) No (2) Unk. (9)

(951) If YES, describe: _____ (952-970)

2. Did the patient travel outside his/her home state in the 7 days before illness began?

Yes (1) No (2) Unk. (9)

Patient home state: <input type="text"/> <input type="text"/> (971-972)											
City/State/Country											
1. _____ (973) _____ (974-1004)	Mo. <input type="text"/>	Day <input type="text"/>	Yr. <input type="text"/>	Date Entered	Mo. <input type="text"/>	Day <input type="text"/>	Yr. <input type="text"/>	Date Left	Mo. <input type="text"/>	Day <input type="text"/>	Yr. <input type="text"/>
2. _____ (1017-1047)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1005-1010)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1011-1016)	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. _____ (1060-1090)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1048-1053)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1054-1059)	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1091-1096)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1097-1102)	<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Please specify which of the following seafoods were eaten by the patient in the 7 days before illness began: (If multiple times, most recent meal)

Type of seafood	Yes (1) No (2) Unk. (9)			Mo. Day Yr.			Any eaten raw? Yes (1) No (2) Unk. (9)			Type of seafood			Yes (1) No (2) Unk. (9)			Mo. Day Yr.			Any eaten raw? Yes (1) No (2) Unk. (9)		
	Clams	(1103)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1104-1109)	(1110)	Shrimp	(1143)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1144-1149)	(1150)					
Crab	(1111)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1112-1117)	(1118)	Crawfish	(1151)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1152-1157)	(1158)						
Lobster	(1119)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1120-1125)	(1126)	Other shellfish	(1159)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1160-1165)	(1166)						
Mussels	(1127)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1128-1133)	(1134)	(specify): _____		<input type="text"/>	<input type="text"/>	<input type="text"/>	(1167-1191)							
Oysters	(1135)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1136-1141)	(1142)	Fish	(1192)	<input type="text"/>	<input type="text"/>	<input type="text"/>	(1193-1198)	(1199)						
									(specify): _____					(1200-1225)							

III. EPIDEMIOLOGIC INFORMATION (CONT.)

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

	Yes (1)	No (2)	Unk. (9)		
A body of water (fresh, salt, or brackish water) ..				If YES, specify body of water location: _____	(1229-1242)
Drippings from raw or live seafood					(1227)
Other contact with marine or freshwater life				If YES to any of the above, answer each:	(1228)
	Yes (1)	No (2)	Unk. (9)		Yes (1) No (2) Unk. (9)
Date of exposure: Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/>				Handling/cleaning seafood ..	(1243) Construction/repairs
Time of exposure: Hour Min. am (1) pm (2) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				Swimming/diving/wading	(1244) Bitten/stung
				Walking on beach/shore/fell on rocks/shells	(1245) Other: (specify)
				Boating/skiing/surfing	(1246) _____

• If skin was exposed to water, indicate type: (1276)

Salt (1)	Brackish (3)	Unk. (9)	
Fresh (2)	Other (9)	(specify): _____	(1277-1284)

Additional comments: _____

• If skin was exposed, did the patient sustain a wound during this exposure, or have a pre-existing wound? (choose one): (1291)

YES, sustained a wound. (1) YES, had a pre-existing wound. (2) YES, uncertain if wound new or old. (3) NO. (4) Unk. (9)

If YES, describe how wound occurred and site on body : _____

(Note: Skin bullae that appear as part of the acute illness should be recorded in section II, Clinical Information, only).

_____ (1292-1320)

If isolate is *Vibrio cholerae* O1 or O139 please answer questions 5 - 8.

5. If patient was infected with *V. cholerae* O1 or O139, to which of the following risks was the patient exposed in the 4 days before illness began:

	Yes (1)	No (2)	Unk. (9)	
Raw seafood				Other person(s) with cholera or cholera-like illness
Cooked seafood				Street-vended food
Foreign travel				Other
				(specify): _____

(1321) (1322) (1323) (1324) (1325) (1326) (1327-1350)

6. If answered "yes" to foreign travel (question III. 5), had the patient been educated in cholera prevention measures before travel?

If YES, check all source(s) of information received:

Pre-travel clinic (1352)	Friends (1355)	Travel agency (1358)
Airport (departure gate) (1353)	Private physician (1356)	CDC travelers' hotline (1359)
Newspaper (1354)	Health department (1357)	Other (specify): (1360) _____

(1361-1400)

7. If answered "yes" to foreign travel (question III. 5), what was the patient's reason for travel? (check all that apply)

To visit relatives/friends (1401)	Other (specify): (1405) _____
Business (1402)	_____ (1406-1426)
Tourism (1403)	Unk. (1427)
Military (1404)	

8. Has patient ever received a cholera vaccine?

Yes (1) No (2) Unk. (9) (1428)

(If YES, specify type most recently received):

Oral (1429) Parenteral (1430)

Most recent date: Mo. Day Yr. (1431-1436)

If domestically acquired illness due to any *Vibrio* species is suspected to be related to seafood consumption, please complete section IV (Seafood Investigation).

ADDITIONAL INFORMATION or COMMENTS

	<p>CDC Use Only</p> <p>Source: (1443)</p> <p>Comment: (1444-1454)</p> <hr/> <p>Syndrome: (1455)</p> <p>CDC Isolate No.</p> <hr/> <p>(1456-1463)</p>
<p>Person completing section I - III: _____</p> <p>Title/Agency: _____</p> <p>Date: Mo. Day Yr. <input type="text"/> <input type="text"/> <input type="text"/> (1437-1442)</p> <p>Tel.: _____</p>	

IV. SEAFOOD INVESTIGATION SECTION

For each seafood ingestion investigated, please complete as many of the following questions as possible. (Include additional pages section IV if more than one seafood type was ingested and investigated.)

1. Type of seafood (e.g., clams): _____ Date consumed: Mo. Day Yr. (1464-1480) (1481-1486)

Time consumed: Hour Min. am (1) pm (2) (1487-8) (1489-90) (1491)

Amount consumed: (1492-1512)

If patient ate multiple seafoods in the 7 days before onset of illness, please note why this seafood was investigated (e.g., consumed raw, implicated in outbreak investigation):

2. How was this fish or seafood prepared? (1513)

Raw (1) Baked (2) Boiled (3) Broiled (4) Fried (5) Steamed (6) Unk. (9) Other (8) (specify): _____ (1514-1530)

3. Was seafood imported from another country? Yes (1) No (2) Unk. (9) If YES, specify exporting country if known: _____ (1531) (1532-1554)

4. Was this fish or shellfish harvested by the patient or a friend of the patient? Yes (1) No (2) Unk. (9) (If YES, go to question 12.) (1555)

5. Where was this seafood obtained? (1556) (Check one)

Oyster bar or restaurant (1) Seafood market (4) Unk. (9)

Truck or roadside vendor (2) Other (8) (specify): _____ (1557-1590)

Food store (3)

6. Name of restaurant, oyster bar, or food store: _____ Tel.: _____

Address: _____

7. If oysters, clams, or mussels were eaten, how were they distributed to the retail outlet? (1591)

Shellstock (sold in the shell) (1) Shucked (2) Unk. (9) Other (8) (specify): _____ (1592-1610)

8. Date restaurant or food outlet received seafood: Mo. Day Yr. (1611-1616)

9. Was this restaurant or food outlet inspected as part of this investigation? Yes (1) No (2) Unk. (9) (1617)

10. Are shipping tags available from the suspect lot? (1618) Yes (1) No (2) Unk. (9)

(Attach copies if available)

11. Shippers who handled suspected seafood: (please include certification numbers if on tags)

12. Source(s) of seafood:

13. Harvest site: _____ Date: Mo. Day Yr. (1619-1639) (1640-1645) (1646)

Status: Approved (1) Conditional (3) Prohibited (2) Other (8) (specify): _____ (1647-1666)

Approved (1) Conditional (3) Prohibited (2) Other (8) (specify): _____ (1667-1687) (1688-1693) (1694) (1695-1714)

14. Physical characteristics of harvest area as close as possible to harvest date:

	Result	Date Measured
		Mo. Day Yr.
Maximum ambient temp.(1715-1718)	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> (1719) (1720-1725)
Surface water temp.(1726-1727)	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> (1728) (1729-1734)
Salinity (ppt)(1735-1736)	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> (1737-1742)
Total rainfall (inches in prev. 5 days)(1743-1744)	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> (1745-1750)
Fecal coliform count(1751-1755)	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> (1756-1761) (Attach copy of coliform data)

15. Was there evidence of improper storage, cross-contamination, or holding temperature at any point? Yes (1) No (2) Unk. (9) (1762) If YES, specify deficiencies:

Person completing section IV: _____ Date: Mo. Day Yr. (1763-1768)

Title/Agency: _____ Tel.: _____