

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
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