

## Attachment 11: Disease-Specific Data

Subsequent tabs in this workbook describe the disease-specific data elements that are requested from each program area.

| CDC Priority (Legacy): | Indicates whether the program specifies the field as:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                        | <b>R - Required</b> - Mandatory for sending the message. If data element is not present, the message will error out.                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                        | <b>P - Preferred</b> - This is an optional variable and there is no requirement to send this information to CDC. However, if this variable is already being collected by the state/territory, or if the state/territory is planning to collect this information because it is deemed important for your own programmatic needs, CDC would like this information sent. CDC preferred variables are the most important of the optional variables to be earmarked for CDC analysis/assessment, even if sent from a small number of states. |
|                        | <b>O - Optional</b> - This is an optional variable and there is no requirement to send this information to CDC. This variable is considered nice-to-know if the state/territory already collects this information or is planning to collect this information, but has a lower level of importance to CDC than the preferred classification of optional data elements.                                                                                                                                                                   |

| CDC Priority (New): | Indicates whether the program specifies the field as:                                                                                                                                                                                                 |
|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                     | <b>R - Required</b> - This data element is <b>mandatory for sending a message</b> . If the required data element is not present, the message will be rejected. The required data elements alone are not sufficient for national surveillance purposes |

## Attachment 11: Disease-Specific Data

|  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | <p><b>1-Priority 1</b> – Highest priority for reporting. These data elements are <b>critical</b> for national surveillance activities. Jurisdiction’s <b>data collection system should be modified to collect Priority 1 data elements</b>. If this data element is not currently collected and available to send, please discuss with the CDC Program whether you can onboard without that element being available and included in the messages. Some CDC programs may request a plan addressing future inclusion of these data elements, if not able to collect and transmit at onboarding.</p> |
|  | <p><b>2 - Priority 2</b> – High priority data element that will <b>support</b> national surveillance activities. If this data element is not currently collected and available to send, <b>please plan to update jurisdiction’s data collection system</b>. Some CDC programs may request a plan addressing future inclusion of these data elements, if not able to collect and transmit at onboarding.</p>                                                                                                                                                                                       |
|  | <p><b>3 - Priority 3</b> – Lower priority data element that <b>should be considered for inclusion in the surveillance system</b> and case notification. Please send if currently collected in the system.</p>                                                                                                                                                                                                                                                                                                                                                                                     |

1/22/2024

| Label/Short Name               | Description                                                                                                                                         |
|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of most recent occurrence | Date of most recent reaction that prompted this report (mm/dd/yyyy)                                                                                 |
| Prior occurrence               | Has the patient had prior reactions?                                                                                                                |
| Date of first occurrence       | Date of first reaction (mm/dd/yyyy)                                                                                                                 |
| Signs and Symptoms             | Signs and symptoms associated with the illness being reported                                                                                       |
| Signs and Symptoms Indicator   | Indicator for associated sign and symptom                                                                                                           |
| Allergy to food (finding)      | Has the patient ever experienced signs or symptoms of an allergic reaction after consumption of any of the following?                               |
| Allergy to drug (finding)      | Has the patient ever experienced signs or symptoms of an allergic reaction after receiving any of the following pharmaceutical or medical products? |
| Anaphylaxis (disorder)         | Has the patient ever experienced anaphylaxis due to this condition?                                                                                 |
| Tick bite                      | In the 12 months before first diagnosis, did the patient notice any tick bites?                                                                     |
| Performing laboratory name     | Testing laboratory                                                                                                                                  |

Value Set Code. Search in PHIN VADS using the following CDC Priority (Legacy)  
link (<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (New)

|                       |  |   |
|-----------------------|--|---|
| N/A                   |  | 1 |
| PHVS_YesNoUnknown_CDC |  | 2 |
| N/A                   |  | 2 |
| TBD                   |  | 1 |
| TBD                   |  |   |
| TBD                   |  | 1 |
| TBD                   |  |   |
| TBD                   |  | 1 |
|                       |  |   |
| PHVS_YesNoUnknown_CDC |  | 2 |
| PHVS_YesNoUnknown_CDC |  | 2 |
| TBD                   |  | 3 |

| Label/Short Name | Description                                                            |
|------------------|------------------------------------------------------------------------|
| AnimalID         | Unique ID for animal submitted for rabies diagnosis                    |
| Date Collected   | Date animal collected for rabies diagnosis                             |
| Species          | Species of animal submitted for rabies diagnosis                       |
| Sex              | Sex of animal                                                          |
| Age              | Age category of animal                                                 |
| Vax Status       | Rabies vaccination status of animal submitted for rabies diagnosis     |
| Human Exposure   | Was there a potential human exposure to the animal submitted           |
| Animal Exposure  | Was there a potential domestic animal exposure of the animal submitted |
| Latitude         | Latitude of Animal Collection                                          |
| Longitude        | Longitude of animal collection                                         |
| Address          | Street Address of animal collection                                    |
| City             | City of animal collection                                              |
| County           | County of animal collection                                            |
| State            | State of animal collection                                             |
| ZipCode          | Zip Code of animal collection                                          |
| DFAResult        | Results of direct fluorescent antibody test                            |
| Date DFA         | Date tested by DFA                                                     |
| DRIT Result      | Results of direct rapid immunohistochemistry test                      |
| Date DRIT        | Date tested by DRIT                                                    |
| Variant          | Rabies virus variant if typed                                          |
| DateTyped        | Date rabies virus typed                                                |

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_AnimalSpecies\_AnimalRabies

PHVS\_Sex\_MFU

PHVS\_AnimalAgeCategory\_NND

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_City\_USGS\_GNIS

PHVS\_County\_FIPS\_6-4

PHVS\_State\_FIPS\_5-2

PHVS\_PosNegUnk\_CDC

PHVS\_PosNegUnk\_CDC

PHVS\_VirusVariantType\_AnimalRabies

Label/Short Name

Case Class Status Code

Case Status Determined

State

State Case ID

Date State Notified

County reporting the case

Date local health department  
notified

Person Reporting to CDC - Name

Person Reporting to CDC - Phone  
Number

Treating HCP

HCP Phone

MMWR year

Event date

Event Type

Subject's Sex

Pregnancy status

Date of Birth

Age at case investigation

Age units at case investigation

Country of usual residence

Occupation

Date Onset

Subject Address County

Date Diagnosis

Clinical presentation

Hospitalized

Final treatment place

Admission Date

ICU

Mechanical ventilation

AIG

Raxibacumab

Outcome

Discharge Date

Deceased Date

Autopsy

Reporting Lab Name

Date Laboratory diagnosis

Date Sample Received at Lab

Date of Acute Specimen Collection

Date of Convalescent Specimen  
Collection

Resulted Test Name

Numeric Result

Result Units

Coded Result Value

Organism Name

Lab Result Text Value

Result Status

Specimens to CDC

Interpretation Flag

Exposure event

Exposure response

Exposure to animals

Exposure to animals products

Contact with undercooked meat

Gardened

Bone meal

Laboratory work

Unknown powder

Suspicious mail

Similar illness

Similar food contact

Similar exposures

Illicit drugs

Received injection

Took public transportation

Transportation type

Other transportation

Attended gathering

Congregate

Travel

Latitude

Longitude

Vaccine

Vaccine received

Vaccine dose

Post exposure antibiotics

Antibiotics not taken

Antibiotics not taken specify

Medical Record ID

State Postal Code

Occupation State

Occupation County

Is the Subject a First Responder

What category of vaccine did the  
subject get

Date last received

Booster Vaccine

Medication Received

Start Date of Treatment or Therapy

Date Treatment or Therapy Stopped

Signs and Symptoms

Signs and Symptoms Indicator

Diet

Smoking Status

Laboratory State

Laboratory City

CSID

Specimen Collected before  
antibiotics

Transferred from Initial Hospital

Antimicrobials given for illness

Antimicrobial Name

Antimicrobial Start Date

Antimicrobial End Date

Number of Days of Treatment

Actual Route of Administration -  
Attempted or Completed

Date AIG Given  
Date Raxibacumab Given  
On vasopressors for any length of time

Route of Infection  
International Destination(s) of Recent Travel

Travel State

Public Transportation Route  
Date Using Public Transportation  
Exposure Source  
Type of Animal Exposure

Animal Type

Lab Name

Contact Type

Location of Contact  
Illicit Drug Specify  
Location Name  
Location Address  
Attendance Date

Locations Routinely Visited  
Time of Day  
Date of last dose  
Post-exposure or Treatment  
Alcohol use frequency

Alcohol use quantity

Hospital Procedure  
Diagnostic Test Findings  
Treatment Type  
Treatment Type Indicator

## Description

Status of the case/event as suspect, probable, confirmed, or not a case per CSTE/CDC/surveillance case definitions.

How was the case status determined, from "Laboratory Results", "Clinical Presentation", "Epi Link"

State reporting case

States use this field to link NEDSS investigations back to their own state investigations.

Date State Notified

County reporting the case

Date local health department notified

Name of the person who is reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Phone Number of the person who is reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Name of the treating health care provider of the subject

Telephone number of the treating health care provider of the subject

MMWR year of report

Event Date ( earliest date associated with case)

Event Type from "Date Onset", "Date Diagnosis", "Date State Notified", "Date LHD notified", "Date Laboratory diagnosis"

Subject's current sex

Indicates whether the subject was pregnant at the time of the event.

Birth Date (*mm/yyyy*)

Subject age at time of case investigation

Subject age units at time of case investigation

Country of usual residence

Provide the subject's occupation

Date Onset

County of residence of the subject

Date Diagnosis

Clinical Presentation (Cutaneous, Inhalation, Meningitis, GI/Oroph, Injection)

Was subject hospitalized because of this event?

List the place of final treatment (only to be sent during a bioterrorism event)

Subject's first admission date to the hospital for the condition covered by the investigation.

Was the subject admitted to Intensive Care Unit for any length of time?

Was the subject on mechanical ventilation for any length of time?

Did the subject receive Anthrax anti-toxin?

Did the subject receive raxibacumab?

Clinical outcome of the patient ("Still hospitalized"; "Discharged"; "Died"; "Other")

Subject's first discharge date from the hospital for the condition covered by the investigation.

If the subject died from this illness or complications associated with this illness, indicate the date of death

If the subject died, was an autopsy performed?

Name of Laboratory that reported test result.

Date Laboratory diagnosis

Date Sample Received at Lab (accession date).

The date the acute specimen was collected.

The date the convalescent specimen was collected.

The lab test that was run on the specimen

Results expressed as numeric value/quantitative result.

The unit of measure for numeric result value.

Coded qualitative result value (e.g., Positive, Negative).

The organism name as a test result. This element is used when the result was reported as an organism.

Textual result value, used if result is neither numeric nor coded.

The Result Status is the degree of completion of the lab test.

Were specimens or isolates sent to CDC for testing?

The interpretation flag identifies a result that is not typical as well as how it's not typical. Examples: Susceptible, Resistant, Normal, Above upper panic limits, below absolute low.

If participated in a documented exposure event, give the name or location

Participated in exposure response?

Exposure to livestock/ wild mammals/ their body fluids?

Exposure to animal products?

Consumed or contact with undercooked or raw meat?

Gardened or other work with soil?

If yes, was bone meal fertilizer or similar used?

Worked in a clinical or microbiological laboratory?

Exposed to unknown powder?

Handled suspicious mail?

Undiagnosed similar illness in friends, family, coworkers, or other contacts?

Consumed same food/drink as lab-confirmed anthrax case?

Exposed to the same environment, animal, or objects as a lab-confirmed anthrax case?

Contact with illicit drugs?

Received an injection?

Took public transportation?

If Took public transportation is "Yes", what form of transportation did the subject take ("Bus"; "Train"; "Light rail"; "Subway"; "Ferry"; "Other")

If the patient took Other form of public transportation, describe

Attended a large gathering (e.g., *concert, sporting event*)?

Attended a place where people congregate (e.g., *shopping mall, religious services*)?

Traveled out of county, state, or country?

Latitude of suspected exposure location (only to be sent during a bioterrorism event)

Longitude of suspected exposure location (only to be sent during a bioterrorism event)

Was anthrax vaccine received?

If anthrax vaccine received is "Yes", specify what was received from "Post-exposure vaccine (1,2,or 3 doses)", "Partial series of pre-exposure vaccine", "Full series of pre-exposure vaccine"

If anthrax vaccine received is "Yes" specify the number of doses received or vaccination status, from "1", "2", "3", "<5", "Outdated on annual boosters", "Fully updated on annual boosters", "Unknown"

Received Post-Exposure Antibiotics

Antibiotics not taken or discontinued?

If Antibiotics were not taken or were discontinued is "Yes", select the primary reason why they were not taken "Low perceived risk", "Adverse events", "Fear of side effects", "Other", "Unknown"

TBD

TBD

TBD

TBD

Is the Subject a First Responder

What category of vaccine did the subject get

Date last received anthrax vaccine

If received a full series of pre-exposure vaccine, is the subject up-to-date on the annual booster vaccine

If the case patient received post exposure antimicrobials, indicate the antimicrobials received

What was the date that the case patient starting taking antimicrobials

What was the date that the case patient stopped taking antimicrobials

Signs and symptoms associated with Anthrax

Indicator for associated signs and symptoms

TBD

What is the patient's current tobacco smoking status?

State where laboratory is located

TBD

CDC specimen ID number from the 50.34 submission form. Example format (10-digit number): 3000123456.

Was the specimen used for testing collected before antibiotics was taken?

Transferred from Initial Hospital

Antimicrobials given for illness

Antimicrobial Name

Antimicrobial Start Date

Antimicrobial End Date

Number of Days of Treatment

What is the route of antibiotic administration?

Date AIG Given

Date Raxibacumab Given

On vasopressors for any length of time

Suspected primary route of infection at time of evaluation (select all that apply):

List all international destinations (country) traveled during the 14 days prior to illness onset

List all domestic destinations (state) traveled to during the 14 days prior to illness onset

Specify public transportation route (e.g. name/number)

Specify date(s) using public transportation

Indicate the type of exposure the patient had in the 14 days prior to illness onset.

Types of exposure to animal.

If exposure type is Animal contact, specify animal the subject had contact with in the 14 days prior to illness onset. If the subject had contact with multiple animals complete separate repeating groups for each one.

If worked in a clinical, microbiological, or animal research laboratory, specify lab.

If linked to confirmed case or contact with similar illness or sign and symptoms, indicate type of contact.

If linked to confirmed case or contact with similar illness or sign and symptoms, indicate geographic location where contact occurred (e.g. city, country, state).

If subject had contact with illicit drugs, specify the name or type of the drug.

Location name of place or event.

Location address of place or event (e.g. country, city, state, county.)

List all date(s) of event or place attendance.

Specify the name of a place that was routinely visited in the 14 days prior to illness onset, such as a place of worship, volunteer, gym, etc.

List the time period during the day when the place was visited

Date last received anthrax vaccine

Indicates if medication received is for post-exposure or anthrax treatment.

In the past 30 days, how often does the patient take alcoholic drinks?

On the days when the case patient drank, about how many drinks did the case patient drink on average?

If subject was hospitalized, were any of the following procedures or treatments done?

Results from procedures or treatments done in the hospital.

Listing of treatment or medical intervention the subject received for this illness.

Indicate if treatment was administered.

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_CaseClassStatus\_NND

PHVS\_State\_FIPS\_5-2

PHVS\_County\_FIPS\_6-4

PHVS\_Sex\_MFU

PHVS\_YesNoUnknown\_CDC

PHVS\_AgeUnit\_UCUM\_NETSS

PHVS\_CountryofBirth\_CDC

PHVS\_County\_FIPS\_6-4

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_LabTestName\_CDC

PHVS\_UnitsOfMeasure\_CDC

PHVS\_PosNegUnk\_CDC

PHVS\_Microorganism\_CDC

PHVS\_ObservationResultStatus\_HL7\_2x

PHVS\_YesNoUnknown\_CDC

PHVS\_AbnormalFlag\_HL7\_2x

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

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PHVS\_YesNoUnknown\_CDC  
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PHVS\_State\_FIPS\_5-2  
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PHVS\_Country\_ISO\_3166-1  
PHVS\_State\_FIPS\_5-2  
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PHVS\_YesNoUnknown\_CDC



CDC Priority (New)

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3

Label/Short Name

StateID

Year

State

County

Week

OnsetDate

ImportedFrom

CountryOfOrigin

StateOfOrigin

ForeignResident

Arbovirus

CaseStatus

Age

AgeUnit

BirthDate

Sex

Race

Ethnicity

ClinicalSyndrome

Fever

Headache

Rash

NauseaVomiting

Diarrhea

Myalgia

ArthralgiaArthritis

ParesisParalysis

StiffNeck

AlteredMentalStatus

Seizures

StateLocalPublicHealthLab

CDCLab

CommercialLab

Serum1Collected

Serum1CollectedDate

Serum2Collected

Serum2CollectedDate

CSFCollected

CSFCollectedDate

CSFPLEocytosis

SerumIgM

SerumPRNT

SerumPCRorNAT

SerumPairedAntibody

CSFIgM

CSFPRNT  
CSFPCRorNAT  
Hospitalized  
Fatality  
DateOfDeath  
LabAcquired

NonLabAcquired

BloodDonor  
BloodTransfusion  
OrganDonor  
OrganTransplant  
BreastFedInfant  
InfectedInUteroOrPerinatal  
Pregnant  
AFP  
IdentifiedByBloodDonorScreening  
DateOfDonation  
LabTestingBy  
TransmissionOrigin  
TransmissionMode  
BloodTissueBorneTransmission  
DomesticTravelDestinationLast  
DomesticTravelDestination2ndLast  
DomesticTravelDestination3rdLast  
ForeignTravelDestinationLast  
ForeignTravelDestination2ndLast  
ForeignTravelDestination3rdLast  
DateUSReturn  
DurationDaysTravelOutsideUS  
ReasonTravel  
PreTravelHealthConsultation  
CountryBirth  
ResidenceStatus  
DurationMonthsVisitOrLiveUS  
MilitaryStatus  
ClinicalSyndrome2  
DurationDaysHospitalized  
ICUAdmission  
SevereEncephalitis  
SevereSeizure  
SevereMeningitis  
SevereAcuteFlaccidParalysis  
SevereGuillainBarreSyndrome  
SevereHemorrhageShock  
SeverePlasmaLeakage

SevereAcuteLiverFailure  
SevereAcuteMyocarditis  
SevereMultiSystemOrganFailure  
SevereOtherSevereSigns  
SevereUnknown  
PreExistingAsthma  
PreExistingChronicHeart  
PreExistingChronicLiver  
PreExistingChronicRenal  
PreExistingDiabetesMellitus  
PreExistingSickleCell  
PreExistingHyperlipidemia  
PreExistingHypertension  
PreExistingObesity  
PreExistingPregnancy  
PreExistingThyroidDisease  
PreExistingOther  
PreExistingUnknown  
S1DENVCollected  
S1DENVCollectedDate  
S1IgMAntiDENV  
S1MolecularDENV  
S1OtherDENVMethod  
S1OtherDENVResult  
S2DENVCollected  
S2DENVCollectedDate  
S2IgMAntiDENV  
S2MolecularDENV  
S2OtherDENVMethod  
S2OtherDENVResult  
OtherSpecCollected  
OtherSpecType  
OtherSpecCollectedDate  
OtherSpecDENVMethod  
OtherSpecDENVResult  
DENVSeroType  
Published  
FeverMedication  
ImmuneSuppressTreatment  
ImmuneSuppressCondition  
ImmuneSuppressDesc  
OtherAfebrileCause  
ChillsRigors  
FatigueMalaise  
Ataxia  
ParkinsonismCogwheel  
SevereShock

SevereHemorrhage  
OtherSymptoms  
Arthralgia  
Arthritis  
Conjunctivitis  
RetroOrbitalPain  
TourniquetTestPositive  
Leukopenia  
AbdominalPainTenderness  
PersistingVomiting  
ExtravascularFluidAccumulation  
MucosalBleeding  
LiverEnlargement  
IncreasingHematocritDecPLT  
SevereBleeding  
SevereOrganInvolvement  
Mother-Infant Case ID Linkage  
  
Mother's Last Menstrual Period Before  
Delivery  
Pregnancy Complications  
Pregnancy Outcome  
Newborn Complications

Other Arboviral Disease Transmission Mode  
Type of Complication

Type of Complications Indicator  
Signs and Symptoms  
Signs and Symptoms Indicator  
Clinical Finding  
Clinical Finding Indicator  
Transmission Mode Detail

Manufacturer of Last Dose Prior to Illness  
Onset

## Description

State-assigned investigation identification code

Current year (new)

State of residence

County of residence

Week of report (new)

Date of onset of symptoms consistent with arboviral infection

Likely location of acquisition of arboviral infection

Country in which infection was likely acquired

State in which infection was likely acquired

(New)

Type of arboviral infection

Case classification according to CDC/CSTE surveillance case definitions

Age at time of case investigation

Age units

Date of Birth

Current sex

Race

Ethnicity

General clinical presentation

Clinical Sign/Symptom

Clinical Sign/Symptom

Clinical Sign/Symptom

Clinical Sign/Symptom

Clinical Sign/Symptom

Clinical Sign/Symptom

Clinical Sign/Symptom

Clinical Sign/Symptom

Clinical Sign/Symptom

Clinical Sign/Symptom

Clinical Sign/Symptom

Testing performed at:

Testing performed at:

Testing performed at:

Was Serum1 collected?

When was Serum1 collected?

Was Serum2 collected?

When was Serum2 collected?

Was CSF collected?

When was CSF collected?

Patient was hospitalized as a result of arboviral illness

Patient died as a result of arboviral infection

Date of death

Patient likely acquired infection due to occupational exposure in a laboratory setting

Patient likely acquired infection due to occupational exposure in a non-laboratory setting

Patient donated blood within 30 days prior to illness onset

Patient received a blood transfusion within 30 days prior to illness onset

Patient donated a solid organ within 30 days prior to illness onset

Patient received a solid organ transplant within 30 days prior to illness onset

Patient was a breastfed infant at time of illness onset

Patient likely acquired infection in utero or perinatal

Patient acquired infection during pregnancy

Patient suffered acute flaccid paralysis

Infection identified through blood donor screening

Date of blood donation

Source of diagnostic testing

Did patient receive medication for fever?  
Is patient on immunosuppressive therapy?  
Does patient have an immunosuppressive condition?  
Description of immunosuppressive condition  
Other afebrile causes  
Did patient have chills or rigors?  
Did patient exhibit fatigue or malaise?  
Did patient have ataxia?  
Was Parkinsonism cogwheel rigidity present?  
Did patient exhibit severe shock?

Did patient have severe hemorrhaging?  
Other symptoms of interest  
Did patient exhibit arthralgia?  
Did patient exhibit arthritis?  
Did the patient have conjunctivitis?  
Did the patient have retro orbital pain?  
Did the patient have a tourniquet test positive?  
Did the patient have leukopenia?  
Did the patient have abdominal pain tenderness?  
Did the patient have persisting vomiting?  
Did the patient have extravascular fluid accumulation?  
Did the patient have mucosal bleeding?  
Did the patient have liver enlargement?  
Did the patient have increasing hematocrit dec PLT?  
Did the patient have severe bleeding?  
Did the patient have severe organ involvement?  
Mother and infant case IDs  
Mother's last menstrual period (LMP) before delivery

Complications of pregnancy  
Pregnancy outcomes  
Complications for newborn  
Other Arboviral unusual and rare disease transmission modes

If the subject experienced severe complications due to this illness, specify the complication(s).

Indicator for associated complication  
Sign and symptoms associated with the illness being reported  
Indicator for associated signs and symptoms  
Clinical findings associated with the illness being reported  
Indicator for associated clinical findings  
For rare arboviral transmission modes, indicate the determined source of infection following investigation of the case.  
Manufacturer of last vaccine dose against this disease prior to illness onset

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

TBD

PHVS\_YesNoUnknown\_CDC

TBD

PHVS\_YesNoUnknown\_CDC

TBD

PHVS\_YesNoUnknown\_CDC

TBD

TBD



CDC Priority (New)

2

2

2

2

2

2

2

2

Label/Short Name

Date Submitted

Clinician Name

Clinician Phone

Symptomatic

ClinicalManifestation

Asplenic

Reason for Splenectomy

Date of Splenectomy

Symptoms

Symptom Fever

Temperature

Temperature Units

Symptom Headache

Symptom Myalgia

Symptom Anemia

Symptom Chills

Symptom Arthralgia

Symptom Thrombocytopenia

Symptom Sweats

Symptom Nausea

Symptom Hepatomegaly

Symptom Splenomegaly

Symptom Cough

Symptoms Other

Complications

Risk Factor Immunosuppressed

Risk Factor Immune Condition

Hospitalization

Death Related to Babesiosis

Treatment

Treatment Medications

Transfusion Associated Recipient

Transfusion Associated Donor

Outdoor Activities

Outdoor Activities Type

Occupation

Wooded Areas

History of Babesiosis

Date of Previous Babesiosis

Tick Bite

Tick Bite Date  
Tick Bite Place  
Travel

Travel Date  
Travel Place  
Infected In Utero

Mother Test Positive After Delivery  
Mother Test Positive Before Delivery

Mother Confirmed Positive Date  
Blood Donor Screening

Blood Donor  
Date of Donation  
Linked Recipient  
Blood Recipient  
Date of Transfusion  
Implicated Product  
Linked Donor  
Organ Donor  
Organ Transplant  
Lab Test  
Date of Specimen Collection  
Lab

Coded Result  
Numeric Result  
Babesia Species  
Parasitemia

Confirmed SPHL  
Date of Onset Approx  
Date of Death Approx  
Date Approx  
Case Classification  
Blood Recipient/Blood Transfusion

Blood Donor  
Mother's Local Record ID

## Description

Date the case report form (extended variables) was submitted to CDC

Name of treating clinician

Phone number for treating clinician

Was the case-patient symptomatic?

Did the case-patient have any clinical manifestations of babesiosis?

Is the case-patient asplenic?

Why was the case-patient's spleen removed?

Date of splenectomy

Indicate case-patient's signs and symptoms

Did the case-patient have a fever?

If fever was indicated, specify temperature (observation includes units)

If fever was indicated, specify Fahrenheit or Celsius

Did the case-patient have a headache?

Did the case-patient have myalgia?

Did the case-patient have anemia?

Did the case-patient have chills?

Did the case-patient have arthralgia?

Did the case-patient have thrombocytopenia?

Did the case-patient have sweats?

Did the case-patient have nausea?

Did the case-patient have hepatomegaly?

Did the case-patient have splenomegaly?

Did the case-patient have a cough?

Indicate any additional symptoms or clinical manifestations

Select all complications

At the time of diagnosis, was the case-patient immunosuppressed?

If the case-patient reported being immunosuppressed, what was the cause?

If the case-patient was hospitalized, indicate the length in days of the hospitalization.

Was the case-patient's death related to the Babesia infection?

Did the case-patient receive antimicrobial treatment for Babesia infection?

If the case-patient was treated, specify which drugs were administered.

Was the case-patient's infection transfusion associated?

Was the case-patient a blood donor identified during a transfusion investigation?

In the eight weeks before symptom onset or diagnosis (use earlier date), did the case-patient engage in outdoor activities?

Specify outdoor activities

Indicate case-patient's occupation

In the eight weeks before symptom onset or diagnosis (use earlier date), did the case-patient spend time outdoors in or near wooded or brushy areas?

Does the case-patient have a previous history of babesiosis in the last 12 months (prior to this report)?

Date of previous babesiosis diagnosis

In the eight weeks before symptom onset or diagnosis (use earlier date), did the case-patient notice any tick bites?

When did the tick bite occur (approximate dates accepted)?

Where (geographic location) did the tick bite occur (city, state, country)?

In the eight weeks before symptom onset or diagnosis (use earlier date), did the case-patient travel (check all that apply)?

When did the travel occur?

Where did the case-patient travel (city, state, country)?

Was the case-patient an infant born to a mother who had babesiosis or Babesia infection during pregnancy?

Did the case-patient's mother test positive for babesiosis after delivery?

Did the case-patient's mother test positive for babesiosis before or at the time of delivery?

Date of mother's earliest positive test result

Donors who have been identified as having a Babesia infection through routine blood donor screening (e.g., IND) by the blood collection agency. May or may not be symptomatic.

Did the case-patient donate blood in the 8 weeks prior to onset?

Date of blood donation(s)

Was a transfusion recipient(s) identified for the case-patient's donation?

Did the case-patient receive a blood transfusion in the 8 weeks prior to onset?

Date of blood transfusion(s)

If a blood product was implicated, specify which type of product.

Was a blood donor identified for the case-patient's transfusion?

Did the case-patient donate an organ in the 30 days prior to onset?

Did the case-patient receive an organ in the 30 days prior to onset?

Indicate each test performed (repeat variables as necessary).

Provide the date the specimen was collected

Information on whether the specimen was tested in public health labs or exclusively in commercial laboratories.

Coded qualitative result value (e.g., positive, negative).

Results expressed as numeric value/quantitative result (e.g., titer).

Provide species identified by the laboratory test (if applicable).

Estimated number of infected erythrocytes expressed as a percentage of the total erythrocytes.

Was the diagnosis confirmed at the state public health laboratory?

If exact date of illness onset is not known, provide approximate date (mm/yyyy).

If exact date of death is not known, provide approximate date (mm/yyyy).

Is the date provided an approximation?

Indicate the case classification status (confirmed, probable, suspect, unknown)

In the year before symptom onset or diagnosis, did the subject receive a blood transfusion?

In the year before symptom onset or diagnosis, did the subject donate blood?

Provide the local record ID used for reporting mother's case (DE Identifier "N/A: OBR-3" in the Generic portion of the message). This will be used for linking the reported congenital case to the mother's reported case.

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_TemperatureUnit\_UCUM  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
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PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

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PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_LabTestName\_Babesiosis

PHVS\_PosNegUnkNotDone\_CDC

PHVS\_LabResult\_Babesiosis

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
N/A



CDC Priority (New)



Label/Short Name

Botulism Lab Confirmed

C. Botulinum Isolated

Botulinum toxin Isolated

Toxin Type Clin

Transmission Category

Botulism Food Source Code

Botulism Food Source Other

Food Tested

Food Tested Method

Food Botulism Positive

Food Bot Positive\_Specify

Food Toxin Type Code

Food Toxin Type Other

Non-food Vehicle

Botulism Other Indicator

Botulism Laboratory Confirmed

Epi-linked

Comments

Reporting Lab Name

Reporting Lab CLIA Number

Local record ID (case ID)

Filler Order Number

Ordered Test Name

Date of Specimen Collection

Specimen Site

Specimen Number

Specimen Source

Specimen Details

Date Sample Received at Lab

Sample Analyzed date

Lab Report Date

Report Status

Resulted Test Name

Numeric Result  
Result Units  
Coded Result Value  
Organism Name

Lab Result Text Value  
Result Status  
Interpretation Flag

Reference Range From

Reference Range To

Test Method

Lab Result Comments

Date received in state public health  
lab

Track Isolate  
Patient status at specimen collection

Isolate received in state public health  
lab

Reason isolate not received  
Reason isolate not received (Other)  
Date received in state public health  
lab

State public health lab isolate id  
number

Case confirmed at state public health  
lab

Case confirmed at CDC lab

## Description

Was botulism laboratory confirmed from patient specimen?

Was *C. botulinum*/ *C. baratii*/ or *C. butyricum* isolated in culture from patient specimen?

Was botulinum toxin confirmed from patient specimen?

If clinical specimen positive, what was its toxin type?

What was the transmission category (e.g., foodborne, wound, infant, other/unknown)?

If food is known or thought to be the source, please specify food type:

If "Other," please specify other food type:

Was food tested?

The technique or method used to perform the test and obtain the test results.  
Examples: Serum Neutralization, Titration, dipstick, test strip, anaerobic culture.

Was food positive for botulism?

If food positive, what was the food item?

If food was positive, what was its toxin type?

If "Other," please specify other toxin type:

If not foodborne botulism, what was the vehicle/exposure (e.g., black tar heroin)

Does the patient have Other Clinical based Botulism?

Was botulism laboratory confirmed from patient specimen?

If botulism not laboratory confirmed from patient specimen or food, was case epi-linked to a confirmed botulism case?

Space to add in general comments

Name of Laboratory that reported test result.

CLIA (Clinical Laboratory Improvement Act) identifier for the laboratory that performed the test.

Sending system-assigned local ID of the case investigation with which the subject is associated. This field has been added to provide the mapping to the case/investigation to which this lab result is associated. This field should appear exactly as it appears in OBR-3 of the Case Notification.

A laboratory generated number that identifies the test/order instance.

Ordered Test Name is the lab test ordered by the physician. It will always be included in an ELR, but there are many instances in which the user entering manual reports will not have access to this information.

The date the specimen was collected.

This indicates the physical location, of the subject, where the specimen originated. Examples include: Right Internal Jugular, Left Arm, Buttock, Right Eye, etc.

A laboratory generated number that identifies the specimen related to this test.

The medium from which the specimen originated. Examples include whole blood, saliva, urine, etc.

Specimen details if specimen information entered as text.

Date Sample Received at Lab (accession date).

The date and time the sample was analyzed by the laboratory.

Date result sent from Reporting Laboratory.

The status of the lab report.

The lab test that was run on the specimen.

Results expressed as numeric value/quantitative result.

The unit of measure for numeric result value.

Coded qualitative result value (e.g., Positive, Negative).

The organism name as a test result. This element is used when the result was reported as an organism.

Textual result value, used if result is neither numeric nor coded.

The Result Status is the degree of completion of the lab test.

The interpretation flag identifies a result that is not typical as well as how it's not typical. Examples: Susceptible, Resistant, Normal, Above upper panic limits, below absolute low.

The reference range from value allows the user to enter the value on one end of a expected range of results for the test. This is used mostly for quantitative results.

The reference range to value allows the user to enter the value on the other end of a valid range of results for the test. This is used mostly for quantitative results.

The technique or method used to perform the test and obtain the test results.

Examples: Serum Neutralization, Titration, dipstick, test strip, anaerobic culture.

Comments having to do specifically with the lab result test. These are the comments from the NTE segment if the result was originally an Electronic Laboratory Report.

Date the isolate was received in state public health laboratory.

Track Isolate functionality indicator

Patient status at specimen collection

Isolate received in state public health lab

Reason isolate not received

Reason isolate not received (Other)

Date received in state public health lab

State public health lab isolate id number

Case confirmed at state public health lab

Case confirmed at CDC lab

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_BotulismFoodSourceType\_FDD

PHVS\_YesNoUnknown\_CDC

Should include mouse bioassay, PCR, ELISA, Culture

PHVS\_YesNoUnknown\_CDC

PHVS\_BotulinumToxinType\_FDD

PHVS\_YesNo\_HL7\_2x

PHVS\_YesNoUnknown\_CDC

PHVS\_BodySite\_CDC

PHVS\_Specimen\_CDC

PHVS\_ResultStatus\_HL7\_2x

PHVS\_LabTestName\_CDC

PHVS\_UnitsOfMeasure\_CDC  
PHVS\_LabTestResultQualitative\_CDC  
PHVS\_Microorganism\_CDC

PHVS\_ObservationResultStatus\_HL7\_2x  
PHVS\_AbnormalFlag\_HL7\_2x

PHVS\_LabTestMethods\_CDC Should include mouse bioassay, PCR, ELISA, Culture

PHVS\_TrueFalse\_CDC  
PHVS\_PatientLocationStatusAtSpecimenCollection

PHVS\_YesNoUnknown\_CDC

PHVS\_IsolateNotReceivedReason\_NND

PHVS\_YesNoUnknown\_CDC

Label/Short Name

Specimen Number

Date First Submitted

Case Outbreak indicator

Source of Infection

Outbreak source

State Case ID

Health care provider

Local Subject ID

Health care provider

Person Reporting to CDC - Name

Person Reporting to CDC - Phone  
Number

Subject Address State

Subject Address County

Age at case investigation

Age units at case investigation

Subject's Sex

Pregnancy status

Country of Birth

Ethnic Group Code

Race Category

Occupation

Case Class Status Code

Stage of disease

Fever

Fever onset date

Maximum temperature

Temperature Units

Sweats

Sweats onset date

arthralgia

arthralgia onset date

headache

headache onset date  
Fatigue  
Fatigue date of onset  
Anorexia  
Anorexia Onset date  
Myalgia  
Myalgia onset date  
weight loss  
weight loss onset date  
endocarditis  
endocarditis onset date  
Orchitis  
Orchitis onset date  
Epididymitis  
Epididymitis onset date  
Hepatomegaly  
Hepatomegaly onset date  
splenomegaly  
splenomegaly onset date  
Arthritis  
Arthritis onset date  
Meningitis  
Meningitis onset date  
spondylitis  
spondylitis onset date  
Symptoms Other  
Symptoms Other details  
Symptoms Other onset date  
Hospitalized  
Admission Date

Discharge Date

Subject Died  
Deceased Date

Treatment status  
Treated doxycycline  
Dose of doxycycline  
Days of doxycycline  
Treated with rifampin  
dosage of rifampin  
days of rifampin  
Treated with streptomycin  
dosage of streptomycin  
days of streptomycin

treated with other drug 1  
name of other drug 1  
dose of other drug 1  
Days other drug 1  
treated with other drug 2  
name of other drug 2  
dose of other drug 2  
Days other drug 2  
treated with other drug 3  
name of other drug 3  
dose of other drug 3  
Days other drug 3

Travel  
travel location 1  
Travel departure date 1  
Travel return date 1  
travel location 2  
Travel departure date 2  
Travel return date 2  
Animal Contact

Birthing product animal  
Birthing product animal other

Skinning contact with animal

Skinning contact with other animal

Hunt animal contact  
Hunt other animal  
Animal Other Contact Type

Other Animal Contact

Other animal contact

Birthing product own animal

Skinning contact owned

Hunt own animal

Other animal owned

Consumed meat or dairy

Milk animal source

Milk Animal other

Cheese

Other animal source of cheese

Meat animal source

Meat animal other

Food product other

Food product animal source

Food Animal other

Milk source country

Milk source other 1

Milk source other 2

Cheese source country

Country cheese was from 1

Country cheese was from 2

Meat source country

Meat source other 1

Meat source other 2

Food product source country

Food source other 1

Food source other 2

Is this case epi-linked to a laboratory

Similar illness

Close contact

Close contact Other

Exposure to Brucella

Location of Exposure

Location of Exposure, other

Risk of exposure

Exposure to Brucella vaccine

PEP received

no PEP was taken

no PEP was taken other  
Complete PEP  
Partial PEP  
Earliest Date Reported to State  
Reporting Lab Name  
Reporting Lab City  
Reporting Lab State  
Reporting Lab Zip  
Received from  
Received city  
Received state  
Date Sample Received at Lab  
Agglutination test name  
Acute total titer  
Convalescent total titer  
Positive Result

Agglutination cut off  
Acute IgG titer Agglutination  
Convalescent IgG titer Agglutination  
Agglutination Positive Result

ELISA test name  
Acute IgG ELISA titer  
Convalescent IgG ELISA titer  
ELISA IgG Positive Result

Acute IgM ELISA titer  
Convalescent IgM ELISA titer  
ELISA IgM Positive Result

ELISA test cut off  
Date of Acute Serum Specimen  
Collection  
Date of Convalescent Serum Specimen  
Collection

Rose Bengal titer  
Rose Bengal positive result  
Rose Bengal test cut off  
Coombs Titer  
Coombs Titer positive result  
Coombs test cut off  
Other serologic test name 1  
Other serologic test titer or value 1  
Other serologic test 1 positive  
Other serologic test 1 cut off  
Other serologic test name 2

Other serologic test value 2  
Other serologic test 2 positive  
Other serologic test 2 cut off  
PCR

PCR other specimen  
Date specimen for PCR collected  
PCR positive  
PCR Species identified

Culture

Culture other specimen  
Date specimen for culture was  
collected  
Culture positive  
Culture Species identified

Pre antimicrobials  
Select Agent Reporting  
Lab exposure  
Exposure reported  
Specimens to CDC  
Specimens still available  
Clinical Presentation  
Clinical Presentation Indicator  
Date of Clinical Presentation  
Medication Administered  
Medication Administered Dose  
Date Treatment or Therapy Started  
Treatment Duration

Type of animal

Animal Ownership

Type of contact

Country of Product Acquisition

Disease Presentation  
Food Product consumed

Contact Type

Similar Illness Contact

Physician Name  
Physician Phone

Treatment Drug Indicator

Antibiotic dose units

Medication Stop Date

International Destination(s) of Recent  
Travel

Travel State

Travel County

Specimen Collected Prior to Therapy  
Travel Outside USA Prior to Illness  
Onset within Program Specific  
Timeframe

Did the Case Travel Domestically  
Prior to Illness Onset

Specify Different Travel Exposure  
Window

Date of Arrival to Travel Destination

## Description

A laboratory generated number that identifies the specimen related to this test.

Date/time the notification was first sent to CDC. This value does not change after the original notification.

Denotes whether the reported case was associated with an identified outbreak.

What is the source of infection from list "naturally-acquired", "lab-aquired", "bioterrorism"

If case outbreak indicator is "Yes", what was the common exposure source, including "Food consumption", "Occupational exposure", "Recreational exposure", "Family", "Close contact", "Sexual contact"

States use this field to link NEDSS investigations back to their own state investigations.

Health care provider name

The local ID of the subject/entity.

Health care provider phone number

Name of the person who is reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Phone Number of the person who is reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

State of residence of the subject

County of residence of the subject

Subject age at time of case investigation

Subject age units at time of case investigation

Subject's current sex

Indicates whether the subject was pregnant at the time of the event.

Country of Birth

Based on the self-identity of the subject as Hispanic or Latino

Field containing one or more codes that broadly refer to the subject's race(s).

Occupation of the case patient, from list "Animal Research", "Medical Research", "Dairy", "Laboratory", "Wildlife", "Rancher", "Slaughterhouse", "Tannery/rendering", "Veterinarian/Vet Tech", "Lives w/person of with an occupation listed here", "Other"  
Status of the case/event as suspect, probable, confirmed, or not a case per CSTE/CDC/ surveillance case definitions.

Stage of disease, including "Acute", "Subacute", "Chronic", "Unknown"

Did patient have a fever?

Onset date of fatigue

Maximum temperature reported

Specify fahrenheit or celsius

Experienced sweats

Onset date of sweats

Experienced arthralgia?

Onset date of arthralgia

Experienced headache

Onset date of headache  
Experienced fatigue  
Onset date of fatigue  
Experienced anorexia  
Onset date of anorexia  
Experienced myalgia  
Onset date of myalgia  
Experienced weight loss  
Onset date of weight loss  
Experienced endocarditis?  
Onset date of endocarditis  
Experienced orchitis  
Onset date of orchitis  
Experienced epididymitis?  
Onset date of epididymitis  
Experienced hepatomegaly  
Onset date of hepatomegaly  
Experienced splenomegaly  
Onset date of splenomegaly  
Experienced arthritis?  
Onset date of arthritis  
Experienced meningitis  
Onset date of meningitis  
Experienced spondylitis  
Onset date of spondylitis  
Were other symptoms or signs experienced  
Describe other symptoms or signs experienced  
Details of other symptoms experienced  
Was subject hospitalized because of this event?  
Subject's first admission date to the hospital for the condition covered by the investigation.  
Subject's first discharge date from the hospital for the condition covered by the investigation.  
Did the subject die from this illness or complications of this illness?  
If the subject died from this illness or complications associated with this illness, indicate the date of death  
  
Status of treatment at time of case notification ("Currently under treatment", "Completed treatment", "Not treated", "No Response")  
treated with doxycycline?  
dosage of doxycycline prescribed  
days of doxycycline prescribed  
treated with rifampin?  
dosage of rifampin prescribed  
days of rifampin prescribed  
treated with streptomycin?  
dosage of streptomycin prescribed  
days of streptomycin prescribed

treated with other drug 1?

If Other drug 1 is "Yes", list name of the drug

If Other drug 1 is "Yes", list the prescribed dosage of this drug

If Other drug 1 is "Yes", list the prescribed duration of this drug

treated with other drug 2?

If Other drug 2 is "Yes", list name of the drug

If Other drug 2 is "Yes", list the prescribed dosage of this drug

If Other drug 2 is "Yes", list the prescribed duration of this drug

treated with other drug 3?

If Other drug 3 is "Yes", list name of the drug

If Other drug 3 is "Yes", list the prescribed dosage of this drug

If Other drug 3 is "Yes", list the prescribed duration of this drug

In the 6 months prior to illness onset did the subject travel outside of the state of residence?

Location of travel 1

If traveled, departure date to first destination

If traveled, return date from first destination

Location of travel 2

If traveled, departure date to second destination

If traveled, return date from second destination

In the 6 months prior to illness onset, did the subject have animal contact?

Which animal(s) did case patient have contact with birthing products ("Cow", "Pig", "Goat", "Sheep", "Dog", "Deer", "Bison", "Elk", "Other")

Other animal with which case patient had contact with birthing products

Which animal did case patient have contact with skinning/slaughtering ("Cow", "Pig", "Goat", "Sheep", "Dog", "Deer", "Bison", "Elk", "Other")?

If animal skinned/slaughtered is "Other", describe which animal(s) the case patient had contact with

Which animal(s) did case patient hunt, from list "Cow", "Pig", "Goat", "Sheep", "Dog", "Deer", "Bison", "Elk", "Other"

If type of animal hunted is "Other", specify the type(s) of animal(s) hunted

If Type of animal contact is "Other" describe the contact

If Type of animal contact is "Other", which animal did case patient have this type of contact including "Cow", "Pig", "Goat", "Sheep", "Dog", "Deer", "Bison", "Elk", "Other"

If Type of animal contact is "Other" and animal is "Other" which animal did case patient have this type of contact

If case patient had contact with birthing products, who owned the animal ("Case", "Private", "Wild", "Commercial", "Unknown")

Who owned the animal which the case patient had contact with skinning/slaughter ("Case", "Private", "Wild", "Commercial", "Unknown")

Who owned the animal which the case patient had contact with hunting from list "Case", "Private", "Wild", "Commercial", "Unknown"

If animal contact type was "Other", describe who owned the animal from this contact, from list "Case", "Private", "Wild", "Commercial", "Unknown"

In the 6 months prior to illness onset, did the subject consume unpasteurized dairy or undercooked meat?

If the subject consumed unpasteurized milk from which animal(s) "Cow", "Pig", "Goat", "Sheep", "Dog", "Deer", "Bison", "Elk", "Other"

If milk animal source is "Other", describe which animal this milk product was from

Consumed fresh or soft cheese from which animal(s), including "Cow", "Pig", "Goat", "Sheep", "Dog", "Deer", "Bison", "Elk", "Other"

If animal source of cheese is "Other", which animal(s) was the source of cheese

Consumed undercooked meat from which animal(s) "Cow", "Pig", "Goat", "Sheep", "Dog", "Deer", "Bison", "Elk", "Other"

If animal source of meat is "Other", list the animal source(s) from which the case patient consumed meat

If food product is "Other", describe other food consumed

If food product is "Other", select the animal sources of this food from list "Cow", "Pig", "Goat", "Sheep", "Dog", "Deer", "Bison", "Elk", "Other"

If food product and animal are "Other", describe which animal this other food was from

Country milk was from, "U.S.", "Other"

If milk source country is "Other", list country

If milk source country is "Other", list country

Country where the cheese product was from. Notification types include "U.S.", "Other"

If cheese source country is "Other", list country

If cheese source country is "Other", list country

Country meat was from, "U.S.", "Other"

If meat source country is "Other", list country

If meat source country is "Other", list country

Country where the food product was from. Notification types include "U.S.", "Other"

If food source country is "Other", list country

If food source country is "Other", list country

Is this case epi-linked to a laboratory-confirmed case?

Similar illness in contact of the subject?

If epi-link to a laboratory-confirmed case or similar illness in a close contact are "Yes", then select the relationship of the contact ("Household", "Neighbor", "Co-worker", "Other")

If Close Contact is "Other", then describe the relationship of the contact

Was the case patient exposed to Brucella, from the list "Clinical specimen", "Isolate", "Vaccine", "Unknown"

If Brucella exposure is selected, where did exposure occur, from list "Clinical", "Laboratory", "Farm/ranch", "Surgery", "Unknown", "Other"

If location of exposure to Brucella is "Other", specify exposure location

Exposure risk classification ("high", "low", "Unknown")

If case patient was exposed to "Vaccine", choose which vaccine patient was exposed to, from list "S19", "RB51", "Rev1", "Other"

Did the subject receive post exposure prophylaxis?

If the case-patient had a known exposure to Brucella and PEP was not taken, why not, from list "Unaware of exposure", "Unavailable", "Allergic", "Pregnant", "Unknown", "Other"

If no PEP taken reason was "Other", describe the reason PEP was not taken

Did the patient complete PEP regimen ("Yes", "No", "Unknown", "Partial")?

If PEP completed is "Partial", Explain why partial pep was taken

Earliest date reported to state public health system

Name of Laboratory that reported test result.

City location of Laboratory that reported test result.

State Laboratory that reported test result.

Zip code of Laboratory that reported test result.

Received from (e.g., lab name, clinician, etc)

Received from city

Received from state

Date Sample Received at Lab (accession date).

Name of agglutination test used

Acute Total antibody titer

Convalscnt Total antibody titer

Based on the acute and covalscnt titers for the agglutination test used, what is the result of the paired total antibody titers (e.g., Positive, Negative, Unknown)?

Cut off value of a positive result for the Agglutination test used

Acute IgG agglutination titer

Convalscnt IgG agglutination titer

Based on the acute and covalscnt titers for the agglutination test used, what is the result of the paired IgG titers (e.g., Positive, Negative, Unknown)?

Name of the ELISA test used

Acute IgG ELISA titer

Convalscnt IgG ELISA titer

Based on the acute and covalscnt titers for the IgG ELISA test used, what is the result of the paired IgG titers (e.g., Positive, Negative, Unknown)?

Acute IgM ELISA titer

Convalscnt IgM ELISA titer

Based on the acute and covalscnt titers for the IgM ELISA test used, what is the result of the paired IgM titers (e.g., Positive, Negative, Unknown)?

ELISA test cut off

The date the acute serum specimen was collected.

The date the convalscnt serum specimen was collected.

Rose Bengal titer

Result of Rose Bengal test (e.g., Positive, Negative, Unknown)?

Cut off value of a positive result for the Rose Bengal test

Coombs Titer

Result of Coombs test (e.g., Positive, Negative, Unknown)?

Cut off value of a positive result for the Coombs test

Name of other serologic test used 1

Titer or value of other serologic test 1

Result of other serologic test 1 (e.g., Positive, Negative, Unknown)?

Cut off value of a positive result for the Other test used 1

Name of other serologic test used 2

Value of other serologic test 2

Result of other serologic test 2 (e.g., Positive, Negative, Unknown)?

Cut off value of a positive result for the Other test used 2

If PCR was done, select on which specimens it was used ("Blood", "Abscess/wound", "Bone marrow", "CSF", "Other")

Describe the specimen if specimen tested by PCR was "Other"

The date the specimen was collected for PCR

Result of PCR (e.g., Positive, Negative, Unknown)?

What Brucella species were identified as a result of PCR ("abortus", "canis", "melitensis", "suis", "ceti", "inopinata", "microti", "neotomae", "pinnipedalis")

If culture was done, which specimens were used ("Blood", "Abscess/wound", "Bone marrow", "CSF", "Other")

Describe the specimen if specimen tested by culture was "Other"

The date the specimen was collected for culture

Result of culture (e.g., Positive, Negative, Unknown)?

What Brucella species were identified as a result of culture ("abortus", "canis", "melitensis", "suis", "ceti", "inopinata", "microti", "neotomae", "pinnipedalis")

Were specimens collected before antimicrobials were taken

Was the select agent reported to CDC

Did a laboratory exposure occur during manipulation of an isolate?

If a laboratory exposure is "Yes", was it reported?

Were specimens or isolates sent to CDC for testing?

are clinical specimens or isolates still available for further testing?

Clinical presentation associated with the illness being reported

Indicator for associated clinical presentation

The date and time, if available, of onset of clinical presentation

Name of antibiotic administered to subject/patient for this illness

Dose of the antibiotic received

Date the treatment or therapy was started

Prescribed duration (in days) of antibiotic treatment

What type of animal did the patient have contact with, or acquire food products from?

Who owns the animals?

What type of activity was the case/patient engaged in that led to contact with the animal(s)?

Where was the food product acquired?

The duration in which the disease presented

What type of animal-based food product did the patient consume?

If linked to confirmed case or contact with similar illness or signs and symptoms, indicate type of contact.

Did the case/patient know anyone else with a similar illness?

Name of the physician or clinician who diagnosed and/or treated the subject

Phone number of the patient's clinician/provider of care

Were antimicrobials prescribed or administered to the subject for this illness or following an exposure?

Dose units of the antimicrobial prescribed or administered

What was the date that the case patient stopped taking antimicrobials

List all international destination (country) traveled to during six months before symptom onset or diagnosis

List all domestic destination (state) traveled to during six months before symptom onset or diagnosis.

List all intrastate destination (county) traveled to during six months before symptom onset or diagnosis.

Was the specimen for culture collected prior to antimicrobial therapy?

Did the subject travel internationally in the six months prior to illness onset?

Did the subject travel domestically in the six months prior to illness onset?

If the travel exposure window used by the jurisdiction is different from that stated in the travel exposure questions, specify the time interval in days here. Otherwise, leave blank.

Date of arrival to travel destination

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_YesNoUnknown\_CDC

PHVS\_State\_FIPS\_5-2

PHVS\_County\_FIPS\_6-4

PHVS\_AgeUnit\_UCUM\_NETSS

PHVS\_Sex\_MFU

PHVS\_YesNoUnknown\_CDC

PHVS\_CountryofBirth\_CDC

PHVS\_EthnicityGroup\_CDC\_Unk

PHVS\_RaceCategory\_CDC

PHVS\_CaseClassStatus\_NND

PHVS\_YesNoUnknown\_CDC

PHVS\_TemperatureUnit\_UCUM

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_CountryofBirth\_CDC  
PHVS\_CountryofBirth\_CDC

PHVS\_CountryofBirth\_CDC  
PHVS\_CountryofBirth\_CDC

PHVS\_CountryofBirth\_CDC  
PHVS\_CountryofBirth\_CDC

PHVS\_CountryofBirth\_CDC  
PHVS\_CountryofBirth\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_State\_FIPS\_5-2

PHVS\_State\_FIPS\_5-2

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

TBD

PHVS\_YesNoUnknown\_CDC

N/A

TBD

N/A

N/A

N/A

TBD

TBD

TBD

TBD

TBD

TBD

TBD

TBD

TBD

TBD

TBD

TBD

N/A

N/A

PHVS\_YesNoUnknown\_CDC

PHVS\_UnitsOfMeasure\_CDC



N/A

PHVS\_Country\_ISO\_3166-1

PHVS\_State\_FIPS\_5-2

PHVS\_County\_FIPS\_6-4

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

N/A

N/A



CDC Priority (New)

TBD  
TBD  
TBD  
TBD  
TBD  
TBD  
TBD  
  
TBD  
  
TBD  
  
TBD  
  
TBD  
TBD  
TBD  
  
TBD  
  
TBD  
3  
3  
2  
  
2

3

1

2

3

2

1

2

3

3

Label/Short Name

Reported symptoms and signs of illness

Travel in 10 days prior to illness

Consumption of undercooked/ raw meat

Consumption of undercooked/ raw poultry

Drinking untreated water

Contact with untreated recreational water

Consumption of raw milk or unpasteurized dairy

Contact with pets, farm animals with *Campylobacter* species

Contact with confirmed/probable case of *Campylobacteriosis*

Consumption or exposure to implicated vehicle

WGS (Whole-Genome Sequencing) ID

Probable – Laboratory Diagnosed

Probable – Epi Linked

PulseNet ID

Travel State

International Destination(s) of Recent Travel

Date of Arrival to Travel Destination

Date of Departure from Travel Destination

Reason for travel related to current illness

## Description

Symptoms and signs associated with illness

Did the case have travel outside of the U.S. in the 10 days before the illness began?

Did the case eat undercooked or raw meat before the illness began?

Did the case eat undercooked or raw poultry before the illness began?

Did the case drink untreated water before the illness began?

Did the case have contact with untreated recreational water before the illness began?

Did the case consume raw milk or unpasteurized dairy before the illness began?

Did the case have contact with pets or farm animals from which *Campylobacter* species were isolated?

Did the case have contact with another probable or confirmed case of *Campylobacteriosis*?

Did the case consume or have exposure to a vehicle implicated in an outbreak or a location in which an implicated food vehicle was prepared or eaten?

The identifier used in PulseNet for the whole genome sequenced isolate that corresponds to the reported case

Probable case is laboratory diagnosed

Probable case is epi linked

State lab ID submitted to PulseNet

Domestic destination, state(s) traveled to

International destination or countries the patient traveled to

Date of arrival to travel destination

Date of departure from travel destination

Reason for travel related to current illness

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

|  | CDC<br>Priority<br>(Legacy) | CDC<br>Priority<br>(New) |
|--|-----------------------------|--------------------------|
|--|-----------------------------|--------------------------|

|                         |   |   |
|-------------------------|---|---|
| PHVS_YesNo_HL7_2x       | P |   |
| PHVS_YesNo_HL7_2x       | P |   |
| N/A                     |   | 1 |
| PHVS_State_FIPS_5-2     |   | 3 |
| PHVS_Country_ISO_3166-1 |   | 3 |
| N/A                     |   | 3 |
| N/A                     |   | 3 |
| PHVS_TravelPurpose_FDD  |   | 3 |

| Label/Short Name                                                            | Description                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Previously Counted Case                                                     | Was patient previously counted as a colonization/screening case?                                                                                                                                                                                                  |
| Previously Reported State Case Number                                       | If patient was previously counted as a colonization/screening case or a CP-CRE case, please provide the related case ID(s)                                                                                                                                        |
| Tracheostomy Tube at Specimen Collection                                    | Did patient have a tracheostomy tube at the time of specimen collection?                                                                                                                                                                                          |
| Ventilator Use at Specimen Collection                                       | Was patient on a ventilator at the time of specimen collection?                                                                                                                                                                                                   |
| Long-term Care Resident                                                     | Did the patient have a stay in a long-term care facility in the 90 days before specimen collection date?                                                                                                                                                          |
| Type of Long-term Care Facility                                             | If patient had a stay in a long-term care facility in the 90 days before specimen collection date, indicate the type of long-term care facility.                                                                                                                  |
| Healthcare Outside Resident State                                           | Indicate if the patient received overnight healthcare within the United States, but outside of the patient's resident state in the year prior to the date of specimen collection.                                                                                 |
| Travel Outside USA Prior to Illness Onset within Program Specific Timeframe | Did the patient travel internationally in the past 1 year from the date of specimen collection?                                                                                                                                                                   |
| International Destination(s) of Recent Travel                               | List the names of the country(ies) outside of the United States the patient traveled to in the year prior to the date of specimen collection, if the patient traveled outside of the United States during that time.                                              |
| Healthcare Outside USA                                                      | Indicate if the patient received overnight healthcare outside of the United States in the year prior to the date of specimen collection.                                                                                                                          |
| Country(ies) of Healthcare Outside USA                                      | List the names of the country(ies) outside of the United States where the patient received overnight healthcare in the year prior to the date of specimen collection, if the patient received overnight healthcare outside of the United States during that time. |
| Type of Location Where Specimen Collected                                   | Indicate the physical location type of the patient when the specimen was collected                                                                                                                                                                                |
| County of Facility                                                          | County of facility where specimen was collected                                                                                                                                                                                                                   |

|                                     |                                                                                                                                                                                                                                                        |
|-------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| State of Facility                   | State of facility where specimen was collected                                                                                                                                                                                                         |
| Infection with Another MDRO         | Does the patient have infection or colonization with another MDRO?                                                                                                                                                                                     |
| Co-infection Type                   | If patient has infection or colonization with another MDRO, indicate the MDRO.                                                                                                                                                                         |
| State Lab specimen ID               | State lab specimen ID                                                                                                                                                                                                                                  |
| WGS ID Number                       | NCBI SRA Accession number (SRX#) We would describe this as: The accession number generated by NCBI's Sequence Read Archive when sequence data are uploaded to NCBI. This provides both the sequence data and metadata on how the sample was sequenced. |
| Date Arrived at Healthcare Facility | Start date of visit/admission                                                                                                                                                                                                                          |
| Date Departed Healthcare Facility   | End date of visit/admission                                                                                                                                                                                                                            |

| Value Set Code. Search in PHIN VADS using the following link<br>( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) | CDC Priority (Legacy) | CDC Priority (New) |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------|
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P                     |                    |
| N/A                                                                                                                                                                               | P                     |                    |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P                     |                    |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P                     |                    |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P                     |                    |
| PHVS_LongTermCareFacilityType_C.auris                                                                                                                                             | P                     |                    |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P                     |                    |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P                     |                    |
| PHVS_Country_ISO_3166-1                                                                                                                                                           | P                     |                    |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P                     |                    |
| PHVS_Country_ISO_3166-1                                                                                                                                                           | P                     |                    |
| PHVS_SpecimenCollectionSettingType_C.auris                                                                                                                                        | P                     |                    |
| PHVS_County_FIPS_6-4                                                                                                                                                              | P                     |                    |

|                              |   |
|------------------------------|---|
| PHVS_State_FIPS_5-2          | P |
| PHVS_YesNoUnknown_CDC        | P |
| PHVS_TypeCoInfection_C.auris | P |
| N/A                          | P |
| N/A                          | P |

|     |  |   |
|-----|--|---|
| N/A |  | 2 |
| N/A |  | 2 |

| Label/Short Name                        | Description                                                                                                                                                                                                              |
|-----------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Smoking status                          | Current smoker (yes, no, unknown)                                                                                                                                                                                        |
| Source of data for case ascertainment   | <ul style="list-style-type: none"> <li>* Hospital/emergency department</li> <li>* Poison control center</li> <li>* Laboratory report</li> <li>* Death certificate</li> <li>* Provider/medical examiner report</li> </ul> |
| Carboxyhemoglobin (COHb) level          | Laboratory test result (%)                                                                                                                                                                                               |
| Intent                                  | <ul style="list-style-type: none"> <li>* Intentional</li> <li>* Unintentional</li> </ul>                                                                                                                                 |
| Primary Language                        | What is the patient's primary language?                                                                                                                                                                                  |
| Marital Status                          | What is the patient's current marital status?                                                                                                                                                                            |
| Education                               | Indicate the highest degree or level of school completed at the time of the event.                                                                                                                                       |
| Poison Control Center Record            | Does the patient have a poison control record indicating exposure to carbon monoxide?                                                                                                                                    |
| Outcome of Poison Control Center Record | If patient has a poison control record, select the outcome identified in the Poison Control Center Record.                                                                                                               |
| Treatment Management Type               | If patient has a poison control record, indicate how the care was managed.                                                                                                                                               |
| Workers Compensation Record             | Does the patient have a worker's compensation record with a finding, problem, diagnosis or other indication of exposure to carbon monoxide or carbon monoxide poisoning?                                                 |
| Type of Workers Compensation Claim      | Indicate the type of claim if patient has a worker's compensation claim with a finding, problem, diagnosis or other indication of exposure to carbon monoxide or carbon monoxide poisoning.                              |
| Fire Related Exposure                   | Was the carbon monoxide exposure related to a fire?                                                                                                                                                                      |
| Power Outage Event                      | Was the carbon monoxide exposure related to a power outage?                                                                                                                                                              |

|                                       |                                                                                                                                                             |
|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Extreme Weather                       | Was the carbon monoxide exposure related to an extreme weather event?                                                                                       |
| Extreme Weather Type                  | Identify the extreme weather event(s) occurring when the patient was exposed to carbon monoxide.                                                            |
| Warning Announcement                  | Immediately before or during the extreme weather event, did patient hear or read about any warnings on the danger of carbon monoxide poisoning?             |
| Exposure Source                       | If patient was physically and temporally associated with a CO-emitting source, specify the source.                                                          |
| Generator Location                    | If the exposure source is generator, where was it placed while it was running?                                                                              |
| Generator Distance                    | If the exposure source was a generator, how many feet was the generator placed from the (house/attached garage/detached garage or other location of event)? |
| Carbon Monoxide Alarm Present         | Patient was in a location where a carbon monoxide alarm was present.                                                                                        |
| Carbon Monoxide Alarm Sounded         | The carbon monoxide alarm sounded.                                                                                                                          |
| Carbon Monoxide Elevated Exposure     | Exposure to an elevated level of CO based on a dedicated or multi-gas meter/instrument (e.g., fire department measurement)?                                 |
| Air Concentration of CO Level (PPM)   | Air concentration of CO Level in parts per million (PPM) at exposure site.                                                                                  |
| Person/Organization Taking CO Reading | If air concentration of CO level was taken, indicate the person or organization taking the CO reading.                                                      |
| Date of Reading                       | What was the date and time, if known, of the CO reading?                                                                                                    |
| Exposure Site Category                | Categorize the location of exposure.                                                                                                                        |
| Public Site of Exposure               | If a public setting where the exposure occurred, please indicate specific site.                                                                             |
| Residential Site of Exposure          | If a residential setting where the exposure occurred, please indicate specific site.                                                                        |
| Epi-Linked                            | Patient was present and exposed in the same event as that of a carbon monoxide poisoning case.                                                              |
| Date and Time of Incident             | Please provide the date and time, if known, of the carbon monoxide incident.                                                                                |

|                                                   |                                                                                                                                                        |
|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| Address of Establishment Where Exposure Occurred  | Street address of the location or establishment where the carbon monoxide exposure occurred. Please provide street, city, county, state, and zip code. |
| City of Establishment Where Exposure Occurred     | City of the location or establishment where the carbon monoxide occurred.                                                                              |
| State of Establishment Where Exposure Occurred    | State of the location or establishment where the carbon monoxide occurred.                                                                             |
| Zip Code of Establishment Where Exposure Occurred | Zip code of the location or establishment where the carbon monoxide occurred.                                                                          |
| County of Establishment Where Exposure Occurred   | County of the location or establishment where the carbon monoxide occurred.                                                                            |
| Event Notes                                       | Description of incident.                                                                                                                               |
| Number of Exposed Cases                           | Total number of exposed persons (including case patient).                                                                                              |
| Average Number of Cigarettes Smoked per Day       | During the past 30 days, please specify the average number of cigarettes smoked per day. There are 20 cigarettes per pack.                             |
| Marijuana Smoking Status                          | Does the patient currently smoke marijuana?                                                                                                            |
| Other Substance                                   | Type of other substance used (e.g., e-cigarette tobacco, e-cigarette THC)                                                                              |
| Underlying Condition(s)                           | Select the patient's preexisting condition(s).                                                                                                         |
| Signs and Symptoms                                | Signs and symptoms associated with the carbon monoxide exposure or poisoning.                                                                          |
| ICD Codes List                                    | ICD Codes in patient's report.                                                                                                                         |
| Treatment Provided                                | Was patient treated for carbon monoxide exposure?                                                                                                      |
| Treatment Type                                    | Specify the treatment type.                                                                                                                            |
| Treatment Location                                | Where did the patient receive treatment?                                                                                                               |
| Treatment Date                                    | Provide the date of treatment.                                                                                                                         |
| Occupation Related to Exposure                    | Is the patient's carbon monoxide exposure related to their current occupation?                                                                         |
| Work Site of Exposure                             | If a work setting where the exposure occurred, please indicate specific site.                                                                          |
| Severe Weather                                    | Was the carbon monoxide exposure related to a severe weather event?                                                                                    |
| Severe Weather Type                               | Identify the severe weather event(s) occurring when the patient was exposed to carbon monoxide.                                                        |
| Intent of Exposure                                | Was the intent of the carbon monoxide exposure self-harm/assault (intentional) or accidental (unintentional)?                                          |
| Carbon Monoxide Level in Air                      | Carbon monoxide level in air measured in parts per million (PPM) at exposure site                                                                      |

|                                    |                                                                                                                                                                                      |
|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Start Date of Treatment or Therapy | Provide the date and time of when the treatment started.                                                                                                                             |
| Underlying Condition(s) Indicator  | Indicator for underlying condition(s)                                                                                                                                                |
| Signs and Symptoms Indicator       | Indicator for associated sign and symptom                                                                                                                                            |
| Specimen Collection Date/Time      | Date of collection of laboratory specimen used for diagnosis of health event reported in this case report. Time of collection should be sent if available.                           |
| Start Date of Treatment or Therapy | Provide the date and time of when the treatment started.                                                                                                                             |
| Type of Workers Compensation Claim | Indicate if the worker's compensation claim is submitted or paid with a finding, problem, diagnosis or other indication of exposure to carbon monoxide or carbon monoxide poisoning. |
| Test Type                          | Please specify Carboxyhemoglobin Level or Pulse CO-oximetry Measurement test.                                                                                                        |
| Test Result Quantitative           | Please send the test results for the selected test type. The unit of test result is percent (%).                                                                                     |
| Specimen Collection Date/Time      | Date of collection of laboratory specimen used for diagnosis of health event reported in this case report. Time of collection should be sent if available.                           |
| Surveillance Data Source           | Type of facility or provider associated with the source of information sent to Public Health                                                                                         |

|                                                                                                                                                                                   |                             |                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------|
| Value Set Code. Search in PHIN VADS using the following link<br>( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) | CDC<br>Priority<br>(Legacy) | CDC<br>Priority<br>(New) |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------|

<https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7876>

|                                                                                                                                                                                   |   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| <a href="https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7876">https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7876</a> | P |
| N/A                                                                                                                                                                               | P |

|                                                                                                                                                                                   |   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| <a href="https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7876">https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.7876</a> | P |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|

|                                |   |
|--------------------------------|---|
| PHVS_Language_ISO_639-2_Alpha3 | P |
|--------------------------------|---|

|                           |   |
|---------------------------|---|
| PHVS_MaritalStatus_HL7_2x | P |
|---------------------------|---|

|                   |   |
|-------------------|---|
| PHVS_Education_CO | P |
|-------------------|---|

|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | P |
|-----------------------|---|

|                                   |   |
|-----------------------------------|---|
| PHVS_PoisonControlCenterRecord_CO | P |
|-----------------------------------|---|

|                       |   |
|-----------------------|---|
| PHVS_TreatmentSite_CO | P |
|-----------------------|---|

|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | P |
|-----------------------|---|

|                                   |   |
|-----------------------------------|---|
| PHVS_WorkersCompensationRecord_CO | P |
|-----------------------------------|---|

|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | P |
|-----------------------|---|

|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | P |
|-----------------------|---|

|                                   |   |
|-----------------------------------|---|
| PHVS_YesNoUnknown_CDC             | P |
| PHVS_ExtremeWeatherType_CO        | P |
| PHVS_YesNoUnknown_CDC             | P |
| PHVS_ExposureSource_CO            | P |
| PHVS_GeneratorLocation_CO         | P |
| PHVS_GeneratorDistance_CO         | P |
| PHVS_YesNoUnknown_CDC             | P |
| PHVS_YesNoUnknown_CDC             | P |
| PHVS_YesNoUnknown_CDC             | P |
| N/A                               | P |
| PHVS_PersonOrgTakingReading_CO    | P |
| N/A                               | P |
| PHVS_ExposureSiteCategory_CO      | P |
| PHVS_SiteofExposure_CO            | P |
| PHVS_ResidentialSiteofExposure_CO | P |
| PHVS_YesNoUnknown_CDC             | P |
| N/A                               | P |

|                              |   |   |
|------------------------------|---|---|
| N/A                          | P |   |
| N/A                          | P |   |
| PHVS_State_FIPS_5-2          | P |   |
| N/A                          | P |   |
| N/A                          | P |   |
| N/A                          | P |   |
| N/A                          | P |   |
| TBD                          | P |   |
| PHVS_YesNoUnknown_CDC        | P |   |
| TBD                          | P |   |
| PHVS_UnderlyingConditions_CO | P |   |
| PHVS_SignsandSymptoms_CO     | P |   |
| PHVS_ICDCodesList_CO         | P |   |
| PHVS_YesNoUnknown_CDC        | P |   |
| PHVS_TreatmentType_CO        | P |   |
| PHVS_TreatmentLocation_CO    | P |   |
| N/A                          | P |   |
| PHVS_YesNoUnknown_CDC        | P |   |
| TBD                          |   | 2 |
| PHVS_YesNoUnknown_CDC        |   | 1 |
| TBD                          |   | 1 |
| TBD                          |   | 1 |
| N/A                          |   | 3 |

|                             |  |   |
|-----------------------------|--|---|
| N/A                         |  | 2 |
| PHVS_YesNoUnknown_CDC       |  | 2 |
| PHVS_YesNoUnknown_CDC       |  | 1 |
|                             |  |   |
| N/A                         |  | 2 |
| N/A                         |  | 2 |
|                             |  |   |
| TBD                         |  | 2 |
| TBD                         |  | 1 |
| N/A                         |  | 2 |
|                             |  |   |
| N/A                         |  | 2 |
| PHVS_DataReportingSource_CO |  | 2 |

Label/Short Name

AGEMM  
AGEYY  
CDCNUM  
CITY  
COUNTY  
DATECOMP  
DOB  
ETHNICITY  
FDANUM  
FNAME  
LNAME  
OCCUPAT  
RACE  
SEX  
STATE  
STEPINUM  
STLABNUM  
FEVER  
NAUSEA  
VOMIT  
DIARRHEA  
VISBLOOD  
CRAMPS  
HEADACHE  
MUSCPAIN  
CELLULIT  
BULLAE  
SHOCK  
OTHER  
MAXTEMP  
CENFAR  
NUMSTLS  
CELLSITE  
BULLSITE  
OTHSPEC2  
AMPMSYMP  
ANTIBYN  
Descant1  
Descant2  
Descant3  
ANTNAM01  
ANTNAM02  
ANTNAM03  
ANTNAM04  
BEGANT1

BEGANT2  
BEGANT3  
BEGANT4  
CDCISOL  
DATEADMN  
DATEDIED  
DATEDISC  
DATESYMP  
DURILL  
ENDANT1  
ENDANT2  
ENDANT3  
ENDANT4  
GSURGTYP  
HEMOTYPE  
HHSYMP  
HOSPN  
IMMTYPE  
LIVTYPE  
MALTYPE  
MISYMP  
OTHCONSP  
PATDIE  
PEPULCER  
ALCOHOL  
DIABETES  
INSULIN  
GASSURG  
HEART  
HEARTFAL  
HEMOTOL  
IMMUNOD  
LIVER  
MALIGN  
RENAL  
RENTYPE  
OTHCOND  
TRTANTI  
TRTCHEM  
TRTRADIO  
TRTSTER  
TRTIMMUN  
TRTACID  
TRTULCER  
SEQDESC  
SEQUELAE  
TRTACISP

TRTANTSP  
TRTCHESP  
TRTIMMSP  
TRTRADSP  
TRTSTESP  
TRTULCSP  
DATESPEC  
SPECIESNAME  
SITE  
STATECON  
SOURCE  
OTHORGAN  
SPECORGAN  
AMBTMFC  
AMNTCONS  
AMPMCONS  
DATEAMBT  
DATEFECL  
DATEH2O  
DATEHAR1  
DATEHAR2  
DATERAIN  
DATESALN  
DATESEAR  
FECALCNT  
H2OSALIN  
HARVSIT1  
HARVSIT2  
HARVST01  
HARVST02  
HARVSTS1  
HARVSTS2  
HHCONSUM  
IMPROPER  
MAMTEMP  
MICONSUM  
RAINFALL  
RESTINV  
SEADISSP  
SEADIST  
SEAHARV  
SEAIMPOR  
SEAIMPSP  
SEAOBT  
SEAOBTSP  
SEAPREP  
SEAPRSP

SH2OTEMP  
SH2OTMFC  
SOURCES  
SHIPPERS  
TAGSAVA  
TYPESEAF  
HARVESTSTATE  
HARVESTREGION  
BIOTYPE  
CHOLVACC  
DATEVACC  
ORALVACC  
PAREVACC  
ELISA  
LATEX  
RISKRAW  
RISKCOOK  
RISKTRAV  
RISKPERS  
RISKVEND  
RISKOTHER  
RISKSPEC  
SEROTYPE  
SPECTOXN  
TOXGENIC  
TRVOTHR  
TRVPREV  
TRVPREV1  
TRVPREV2  
TRVPREV3  
TRVPREV4  
TRVPREV5  
TRVPREV6  
TRVPREV7  
TRVPREV8  
TRVPREV9  
TRVREAS1  
TRVREAS2  
TRVREAS3  
TRVREAS4  
TRVREAS5  
TRVREAS6  
TRVROTHR  
AMPMEXP  
HANDLING  
SWIMMING  
WALKING

BOATING  
CONSTRN  
BITTEN  
ANYWLIFE  
BODYH2O  
CONSTRN  
DATEEXPO  
DATEWHI1  
DATEWHI2  
DATEWHI3  
DATEWHO1  
DATEWHO2  
DATEWHO3  
FISHSP  
H2OCOMM  
H2OTYPE  
HHEXPOS  
LOCEXPOS  
MIEXPOS  
OTHEREXP  
OTHERH2O  
OTHSHSP  
OUTBREAK  
OUTBRKSP  
CLAMS  
CRAB  
LOBSTER  
MUSS  
OYSTER  
SHRIMP  
CRAY  
OTHSH  
FISH  
RCLAM  
RCRAB  
RLOBSTER  
RMUSS  
ROYSTER  
RSHRIMP  
RCRAY  
ROTHSH  
RFISH  
DATECLAM  
DATECRAB  
DATELOBS  
DATEMUSS  
DATEOYSTER

DATESHRI  
DATECRAY  
DATEOTSHH  
DATEFISH  
SPECEXPO  
STRESID  
TRAVEL  
WHERE01  
WHERE02  
WHERE03  
WOUNDEXP  
WOUNDSP  
Specify Different Exposure Window

PulseNet ID  
WGS ID Number

## Description

Age in months

Age in years

CDC Number

City

County

Date completing form

Date of birth

Hispanic or Latino origin?

FDA Number

First 3 letters of first name

First 3 letters of last name

Occupation

Race

Sex

State of exposure (usually reporting state)

State Number

State Lab Number

Fever

Nausea

Vomiting

Diarrhea

Bloody stool

Abdominal cramps

Headache

Muscle Pain

Cellulitis

Bullae

Shock

Other

Symptom: Maximum temp of fever

Fever measured in units of C or F

Symptom: # of stools/24 hours

Symptom: Site of cellulitis

Symptom: Site of Bullae

Symptom: Specify other Symptoms

Seafood Investigation: Onset in am or pm

Did patient receive antibiotics?

Name of 1st Antibiotic

Name of 2nd Antibiotic

Name of 3rd Antibiotic

Name of 1st Antibiotic (old)

Name of 2nd Antibiotic (old)

Name of 3rd Antibiotic (old)

Name of 4th Antibiotic (old)

Date began Antibiotic #1

Date began Antibiotic #2  
Date began Antibiotic #3  
Date began Antibiotic #4  
CDC Isolate No.  
Date admitted to hospital  
Date of death  
Date of discharge from hospital  
Date of symptom onset  
# days ill  
Date ended Antibiotic #1  
Date ended Antibiotic #2  
Date ended Antibiotic #3  
Date ended Antibiotic #4  
Pre-existing: Type of gastric surgery  
Pre-existing: Type of hemotological disease  
Hour of symptom onset  
Hospitalized?  
Pre-existing: Type of Immunodeficiency  
Pre-existing: type of liver disease  
Pre-existing: Type of Malignancy  
Minute of symptom exposure  
Pre-existing: Type of Other condition  
Did patient die?  
Pre-existing: Peptic ulcer  
Pre-existing: Alcoholism  
Pre-existing: Diabetes  
Pre-existing: on insulin?  
Pre-existing: Gastric surgery  
Pre-existing: Heart disease  
Pre-existing: Heart failure?  
Pre-existing: Hematologic disease  
Pre-existing: Immunodeficiency  
Pre-existing: Liver disease  
Pre-existing: Malignancy  
Pre-existing: Renal disease  
Pre-existing: Type of renal disease  
Pre-existing: Other  
Type of treatment received: antibiotics  
Type of treatment received: chemotherapy  
Type of treatment received: radiotherapy  
Type of treatment received: systemic steroids  
Type of treatment received: immunosuppressants  
Type of treatment received: antacids  
Type of treatment received: H2 Blocker or other ulcer medication  
Describe Sequelae  
Sequelae?  
If previously treated with Antacids, specify

If previously treated with Antibiotics, specify  
If previously treated with chemotherapy, specify  
If previously treated with immunosuppressants, specify  
If previously treated with radiotherapy, specify  
If previously treated with steroids, specify  
If treated with ulcer meds, specify  
Date specimen collected  
Species  
If other source, specify site from which Vibrio was isolated  
Was Species confirmed at State PH Lab?  
Specimen source  
Other organism isolated from specimen?  
Specify other organism isolated  
Seafood Investigation: Maximum ambient temp units - F or C  
Seafood Investigation: Amount of shellfish consumed  
Seafood Investigation: Shellfish consumed in am or pm  
Seafood investigation: Date ambient temp measured  
Seafood Investigation: Date of fecal count  
Seafood Investigation: Date water temp measured  
Seafood Investigation: Date of harvest #1  
Seafood Investigation: Date of harvest #2  
Seafood Investigation: Date total rain fall recorded  
Seafood Investigation: Date salinity measured  
Seafood Investigation: Date restaurant rec'd seafood  
Seafood Investigation: Fecal Coliform Count  
Seafood Investigation: Results of Salinity test  
Seafood Investigation: Harvest Site #1  
Seafood Investigation: Harvest Site #2  
Seafood Investigation: Status of Harvest Site #1  
Seafood Investigation: Status of Harvest Site #2  
Seafood Investigation: Specify if Status for Harvest Site #1 = other  
Seafood Investigation: Specify if Status for Harvest Site #2 = other  
Seafood Investigation: Hour of seafood consumption  
Seafood Investigaion: Improper Storage?  
Seafood Investigation: Maximum ambient temp  
Seafood Investigation: Minute of seafood consumption  
Seafood Investigation: Total rainfall in Inches  
Seafood Investigation: Investigation of Restaurant?  
Seafood Investigation: Specify how shellfish distributed  
Seafood Investigation: How is shellfish distributed?  
Seafood Investigation: Was shellfish harvested by patient or friend?  
Seafood Investigation: Was seafood imported?  
Seafood Investigation: Specify country of Import  
Seafood Investigation: where was seafood obtained?  
Seafood Investigation: Specify from where seafood was obtained  
Seafood Investigation: How was seafood prepared?  
Seafood Investigation: Specify how seafood was prepared (if other)

Seafood Investigation: Surface water temperature  
Surface water temp units in F or C?  
Sources of seafood  
Shippers who handled suspected seafood (certification numbers)  
Seafood investigation: Are tags available from suspect lot?  
Seafood investigation: Type of shellfish consumed  
State in which seafood was harvested  
Region in which seafood was harvested  
Cholera Only: biotype?  
Cholera Only: Patient ever received cholera vaccine  
Cholera Only: Date cholera vaccine received  
Cholera Only: Oral cholera vaccine received  
Cholera Only: Parenteral cholera vaccine received  
Cholera Only: Elisa test performed for Cholera toxin testing?  
Cholera Only: Latex Agglut. performed for Cholera toxin testing?  
Cholera Only: Raw seafood  
Cholera Only: Cooked seafood  
Cholera Only: Foreign travel  
Cholera Only: Other person(s) with cholera or cholera-like illness  
Cholera Only: Street-vended food  
Cholera Only: Other  
Cholera Only: Other risk specified  
Cholera Only: Cholera Serotype  
Cholera Only: Specify other toxin test used for Cholera (if other)  
Cholera Only: is it toxigenic?  
Cholera prevention education: specify other source of education  
Cholera prevention education prior to travel?  
Cholera prevention: Pre-travel clinic  
Cholera prevention: Airport  
Cholera prevention: Newspaper  
Cholera prevention: Friends  
Cholera prevention: Private physician  
Cholera prevention: Health department  
Cholera prevention: Travel agency  
Cholera prevention: CDC travelers' hotline  
Cholera prevention: Other  
Reason for travel: Visit friends/relatives  
Reason for travel: Business  
Reason for travel: Tourism  
Reason for travel: Military  
Reason for travel: Other  
Reason for travel: Unknown  
Cholera, reason for travel: specify if other  
Seafood Investigation: Exposure to seawater in am or pm  
Exposure: handling/cleaning seafood  
Exposure: Swimming/diving/wading  
Exposure: Walking on beach/shore/fell on rocks/shells

Exposure: Boating/skiing/surfing  
Exposure: Construction/repairs  
Exposure: Bitten/stung  
Exposure: Contact with other marine/freshwater life  
Exposure: Exposure to a body of water  
Exposure to water via construction  
Exposure: Date of exposure to seawater  
Date traveled/entered destination #1  
Date traveled/entered destination #2  
Date traveled/entered destination #3  
Date left/returned home #1  
Date left/returned home #2  
Date left/returned home #3  
Type of fish  
Exposure: Comments on water exposure  
Exposure: Type of water exposure  
Exposure: Hour of seawater exposure  
Exposure: location of water exposure  
Exposure: Minute of seawater exposure  
Exposure: Other exposure  
Exposure: Exposed to other water not listed?  
Specify other shellfish consumed  
Is case part of outbreak?  
If part of an outbreak, Specify outbreak  
Consumption: clams  
Consumption: crab  
Consumption: lobster  
Consumption: mussels  
Consumption: oysters  
Consumption: shrimp  
Consumption: crawfish  
Consumption: other shellfish  
Consumption: other fish  
Raw consumption: clams  
Raw consumption: crab  
Raw consumption: lobster  
Raw consumption: muss  
Raw consumption: oyster  
Raw consumption: shrimp  
Raw consumption: crawfish  
Raw consumption: other shellfish  
Raw consumption: other fish  
Date of seafood consumption: clams  
Date of seafood consumption: crab  
Date of seafood consumption: lobster  
Date of seafood consumption: mussels  
Date of seafood consumption: oysters

Date of seafood consumption: shrimp

Date of seafood consumption: crawfish

Date of seafood consumption: other shellfish

Date of seafood consumption: other fish

Specify other seawater/shellfish dripping exposure (if other)

State of residence

Exposure to travel outside home state in previous 7 days?

Travel destination #1

Travel destination #2

Travel destination #3

Did patient incur a wound before/during exposure?

If patient incurred wound before/during exposure, describe wound

If the epidemiologic exposure window used by the jurisdiction is different from that stated in the exposure questions, specify the time interval in days here. Otherwise, leave blank.

State lab ID submitted to PulseNet

Whole Genome Sequencing (WGS) ID Number

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

N/A

P

N/A

N/A



CDC Priority (New)

1

1

Label/Short Name

Date of Last Evaluation by a Healthcare Provider

Primary cause of death from death certificate

Secondary cause of death from death certificate

Was an autopsy performed?

Final Anatomical Diagnosis of Death from Autopsy Report

If not a case of CRS, select reason

Gestational Age at Birth (in weeks)

Age at Diagnosis

Age (unit) at Diagnosis

Birth Weight

Birth Weight (unit)

Cataracts (Complication)

Hearing Impairment (loss) (Complication)

Congenital Heart Disease (Complication)

Patent Ductus Arteriosus (Complication)

Peripheral Pulmonic Stenosis (Complication)

Congenital Glaucoma (Complication)

Pigmentary Retinopathy (Complication)

Developmental Delay or Mental Retardation (Complication)

Meningoencephalitis (Complication)

Microencephaly (Complication)

Purpura (Complication)

Enlarged Spleen (Complication)

Enlarged Liver (Complication)

Radiolucent Bone Disease (Complication)

Neonatal Jaundice (Complication)

Low Platelets (Complication)

Dermal Erythropoieses (Blueberry Muffin Syndrome) (Complication)

Other Complication(s)

Specify Other Complication(s)

Was laboratory testing done for Rubella on this subject?

Test Type

Test Result

Sample Analyzed Date

Test Method

Date Collected

Specimen Source

Was CRS virus genotype sequenced?

Was Rubella genotype sequenced?

Were the specimens sent to CDC for genotyping (molecular typing)?

Specimen type sent to CDC for genotyping

Date sent for genotyping

Type of Genotype Sequence

Did the mother have a rash?  
What was the mother's rash onset date?  
Mother's Rash Duration (in days)  
Did the mother have a fever?  
What was the mother's fever onset date?  
Mother's Fever Duration (in days)  
Did the mother have arthralgia/arthritis?  
Did the mother have lymphadenopathy?  
Other clinical features of maternal illness  
Mother's birth country  
Length of time mother has been in the US  
Mother's age at delivery  
Mother's occupation at time of conception  
Did the mother attend a family planning clinic prior to conception of this infant?  
Number of children less than 18 years of age living in household during this pregnancy

Were any of the children living in the household immunized with Rubella-containing

Number of children less than 18 years of age immunized with the rubella vaccine

Was prenatal care obtained for this pregnancy?  
Date of first prenatal visit for this pregnancy  
Where was prenatal care for this pregnancy obtained?  
Did the mother have serological testing prior to this pregnancy?  
Was there a rubella-like illness during this pregnancy?  
Month of pregnancy in which symptoms first occurred  
Rubella Lab Testing Mother

Was Rubella diagnosed by a physician at time of illness?  
If Rubella was not diagnosed by a physician, diagnosed by whom?

Was Rubella serologically confirmed at time of illness?  
Serologically Confirmed Date  
Serologically Confirmed Result  
Mother Reported Rubella Case  
Does the mother know where she might have been exposed to Rubella?  
If location of exposure is unknown, did the mother travel outside the US during the fi

International Destination(s) of recent travel  
Date left for travel  
Date returned from travel  
Was the mother directly exposed to a confirmed case?  
If mother directly exposed to a confirmed Rubella case, specify the relationship  
Mother's date of exposure to a confirmed rubella case  
Has mother given birth in the US previously?  
If mother has given birth in US, list dates (years)  
Number of previous pregnancies

Number of live births (total)

If mother has given birth in US, number of births delivered in U.S.

Mother immunized with rubella-containing vaccine?

Source of mother's Rubella-containing vaccine information

Source of mother's rubella-containing vaccine

Vaccine Administered

Vaccine Manufacturer

Vaccine Lot Number

Vaccine Administered Date

US Acquired

Specimen from mother or infant

At the time of cessation of pregnancy, what was the age of the fetus (in weeks)?

Birth State

Mother's Country of Residence

Mother's pre-pregnancy serological test date.

Mother's pre-pregnancy serological test interpretation.

Pregnancy outcome

Number of doses received on or after 1st birthday

Date of last dose prior to illness onset

## Description

The date the patient was last evaluated by a healthcare provider

The primary cause of subject's death, as noted on the death certificate

The secondary cause of subject's death, as noted on the death certificate.

Was an autopsy performed on the subject's body?

The final anatomical cause of subject's death

The reason this was not a case of CRS.

The subject's gestational age (in weeks) at birth

The subject's age at the time of diagnosis.

The age units at the time of diagnosis

The subject's birth weight

The subject's birth weight units

Did/does the subject have cataracts?

Did/does the subject have hearing impairment (loss)?

Did the subject have a congenital heart disease?

Did/does the subject have patent ductus arteriosus?

Did/does the subject have peripheral pulmonic stenosis?

Did/does the subject have congenital glaucoma?

Did/does the subject have pigmentary retinopathy?

Did/does the subject have developmental delay or mental retardation?

Did the subject have meningoencephalitis?

Did the subject have microencephaly?

Did the subject have purpura?

Did/does the subject have an enlarged spleen?

Did/does the subject have an enlarged liver?

Did the subject have radiolucent bone disease?

Did the subject have jaundice?

Did/does the subject have low platelets?

Did subject have dermal erythropoiesis?

Did the subject develop other conditions as a complication of this illness?

Please specify the other complication(s) the subject developed, during or as a result of this illness.

Was laboratory testing done for Rubella on this subject?

Epidemiologic interpretation of the type of test(s) performed for this case

Epidemiologic interpretation of the results of the tests performed for this case

The date the lab test was performed

The technique or method used to perform the test and obtain the test results.

Date of specimen collection

The medium from which the specimen originated.

Identifies whether the CRS virus was genotype sequenced

Identifies whether the Rubella virus was genotype sequenced

Were clinical specimens sent to CDC laboratories for genotyping (molecular typing)?

Specimen type sent to CDC for genotyping

The date the specimens were sent to the CDC laboratories for genotyping.

Identifies the genotype sequence of the Rubella virus

Did the mother have a maculopapular rash?  
 What was the mother's rash onset date?  
 How many days did the mother's rash being reported in this investigation last?  
 Did the mother have a fever?  
 What was the mother's rash onset date?  
 How many days did the mother's rash being reported in this investigation last?  
 Did the mother have arthralgia/arthritis?  
 Did the mother have lymphadenopathy?  
 Mother's other clinical features of maternal illness  
 The mother's country of birth  
 Length of time (in years) the mother has been in the U.S.  
 The age of the mother when the infant (subject) was delivered  
 The mother's occupation at time of this conception  
 Did the mother attend a family planning clinic prior to conception of this infant?  
 The number of the mother's children less than 18 years of age living in household during this pregnancy  
 Were any of the mother's children less than 18 years of age immunized with the rubella vaccine?  
 The number of the mother's children less than 18 years of age immunized with the rubella vaccine  
 Was prenatal care obtained for this pregnancy?  
 Date of the first prenatal visit for this pregnancy  
 Where was the prenatal care for this pregnancy obtained?  
 Did the mother have serological testing prior to this pregnancy?  
 Was there a rubella-like illness during this pregnancy?  
 The month of pregnancy that Rubella-like symptoms appeared  
 Was Rubella lab testing performed for the mother in conjunction with this pregnancy?  
  
 Was the mother diagnosed with Rubella by a physician at time of illness?  
 If the mother was not diagnosed with Rubella by a physician, then diagnosed by whom?  
 Was Rubella serologically confirmed (mother) at time of illness?  
 The date Rubella was serologically confirmed (mother)  
 The result of the Rubella serological confirmation (mother)  
 Has the mother ever been reported as a Rubella case?  
 Did the mother know where she might have been exposed to Rubella?  
 If the Rubella exposure is unknown, did the mother travel outside the US during the first(1st) trimester of pregnancy?  
 List any international destinations of recent travel  
 The date the mother left for all international travel  
 The date the mother returned to United States from travel  
 Was the mother directly exposed to a confirmed Rubella case?  
 The mother's relationship to the confirmed Rubella case  
 The mother's exposure date to the confirmed rubella case  
 Has mother given birth in the US previously?  
 List years in which mother has given birth in US previously  
 Mother's number of previous pregnancies

Mother's total number of live births

Mother's number of births delivered in U.S.

Was the mother immunized with Rubella vaccine?

Source of mother's Rubella immunization information

Source of mother's Rubella vaccine

The type of vaccine administered, (e.g., Varivax, MMRV). First question of a repeating group of vaccine questions.

Manufacturer of the vaccine. Second question of a repeating group of vaccine questions.

The vaccine lot number of the vaccine administered. Third question of a repeating group of vaccine questions.

The date that the vaccine was administered. Fourth question of a repeating group of vaccine questions.

Sub-classification of disease or condition acquired in the US

Is the specimen from the mother or infant?

If applicable, at the time of cessation of pregnancy, what was the age of the fetus (in weeks)?

State where the subject was born

What is the mother's country of residence?

If pre-pregnancy serological testing was performed, what was the date of mother's pre-pregnancy serological test?

If pre-pregnancy serological testing was performed, what was the interpretation of mother's pre-pregnancy serological test?

What was the outcome of the current pregnancy

The number of vaccine doses against this disease which the mother received on or after their first birthday

Date of mother's last vaccine dose against this disease prior to illness onset

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

PHVS\_NoCaseReason\_CRS

PHVS\_AgeUnit\_UCUM

PHVS\_WeightUnit\_UCUM

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_LabTestProcedure\_Rubella

PHVS\_LabTestInterpretation\_VPD

PHVS\_LabTestMethod\_CDC

PHVS\_SpecimenSource\_VPD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_SpecimenSource\_VPD

PHVS\_Genotype\_Rubella

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_Country\_ISO\_3166-1

PHVS\_Occupation\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_PrenatalCareProvider\_Rubella

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_LabTestInterpretation\_VPD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_Country\_ISO\_3166-1

PHVS\_YesNoUnknown\_CDC

PHVS\_Relationship\_VPD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_ImmunizationInformationSource\_CRS

PHVS\_PrenatalCareProvider\_Rubella

PHVS\_VaccinesAdministeredCVX\_CDC\_NIP

PHVS\_ManufacturersOfVaccinesMVX\_CDC\_NIP

PHVS\_CaseClassificationExposureSource\_NND

| Label/Short Name | Description                                                                                                                                                                                                |
|------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| RECTYPE          | Record type will determine how the record is handled when it arrives at CDC.                                                                                                                               |
| UPDATE           | Currently not implemented.                                                                                                                                                                                 |
| STATE            | Reporting State FIPS code - (e.g., "06", "13").                                                                                                                                                            |
| YEAR             | MMWR Year (2-digits) for which case information reported to CDC.                                                                                                                                           |
| CASEID           | Unique Case ID (numeric only) assigned by the state.                                                                                                                                                       |
| SITE             | Location code used by the state to indicate where report originated and who has responsibility for maintaining the record. (NOTE: STD*MIS software substitutes a '#' for the leading 'S' in codes listed). |
| WEEK             | MMWR Week on Surveillance Calendar, i.e., week for which case information reported to CDC.                                                                                                                 |
| EVENT            | Event (disease) code for the disease being reported.                                                                                                                                                       |
| COUNT            | For case records this field will always contain "00001".                                                                                                                                                   |
| COUNTY           | FIPS code for reporting county (999=Unknown)                                                                                                                                                               |
| BIRTHDATE        | Date of birth of infant in YYYYMMDD format (99999999=Unknown)                                                                                                                                              |
| AGE              | Estimated Gestational Age in weeks - (e.g., "038", "042") (999= Unknown)                                                                                                                                   |
| AGETYPE          | Indicates the units (weeks) for the AGE field.                                                                                                                                                             |

|             |                                                             |
|-------------|-------------------------------------------------------------|
| RACE        | Race of Mother.                                             |
| HISPANIC    | Indicator for Mother's Hispanic ethnicity.                  |
| EVENTDATE   | Date of Report to Health Department in YYMMDD format        |
| DATETYPE    | A code describing the type of date provided in EVENTDATE.   |
| CASE STATUS | Recode of Case Classification.                              |
| OUTBREAK    | Indicates whether the case was associated with an outbreak. |

|          |                                                                         |
|----------|-------------------------------------------------------------------------|
| INFOSRCE | Information Source/Provider Codes (from Interview Record if available). |
|----------|-------------------------------------------------------------------------|

|          |                                                                |
|----------|----------------------------------------------------------------|
| DETECTED | Method of Case Detection (from Interview Record if available). |
|----------|----------------------------------------------------------------|

|        |                                                                                                                     |
|--------|---------------------------------------------------------------------------------------------------------------------|
| MZIP   | Zip Code for Mother's Residence                                                                                     |
| MSTATE | FIPS Code for Mother's State of Residence. Code 98 for Mexico and 97 for any other non-USA residence. (999=Unknown) |

|         |                                                                                                                        |
|---------|------------------------------------------------------------------------------------------------------------------------|
| MCOUNTY | FIPS Code for Mother's County of Residence. Code 998 for Mexico and 997 for any other non-USA residence. (999=Unknown) |
|---------|------------------------------------------------------------------------------------------------------------------------|

|        |                                                               |
|--------|---------------------------------------------------------------|
| MBIRTH | Mother's Date of Birth in YYYYMMDD format. (99999999=Unknown) |
|--------|---------------------------------------------------------------|

|          |                                                                                                  |
|----------|--------------------------------------------------------------------------------------------------|
| MARITAL  | Mother's Marital Status.                                                                         |
| LMP      | Date of Mother's Last Menstrual Period before delivery in YYYYMMDD format. (99999999=Unknown)    |
| PRENATAL | Did mother have prenatal care?                                                                   |
| PNCDATE1 | Date of mother's first prenatal visit in YYYYMMDD format. (99999999=Unknown)                     |
| DATEA    | Date of mother's most recent non-treponemal test in YYYYMMDD format. (99999999=Unknown)          |
| RESULTA  | Result of mother's most recent non-treponemal test.                                              |
| DATEB    | Date of mother's first non-treponemal test in YYYYMMDD format. (99999999=Unknown)                |
| RESULTB  | Result of mother's first non-treponemal test.                                                    |
| TITER    | Titer of mother's most recent non-treponemal test. (The titer for date b is in columns 214-217). |
| VITAL    | Vital status of infant/child.                                                                    |
| DEATHDAT | Date of death of infant/child in YYYYMMDD format.                                                |
| BIRTHWT  | Birthweight in grams (9999=Unknown)                                                              |
| REACSTS  | Did infant/child have reactive non-treponemal test for syphilis?                                 |

REACDATE            Date of infant/child's first reactive non-treponemal test for syphilis in YYYYMMDD format. (99999999=Unknown)

DARKFLD            Did the infant/child, placenta, or cord have darkfield exam, DFA, or special stains?

XRAYS                Did infant/child have long bone x-rays?

CSFVDRL            Did infant/child have a CSF-VDRL?

TREATED            Was infant/child treated?

CLASS                Case Classification.

ID126                CDC 73.126 form Case ID number  
(99999999=Unknown)

VERSION            CDC 73.126 Form Version.

TITERB               Titer of mother's first non-treponemal test  
b.

|            |                                                                                                                                           |
|------------|-------------------------------------------------------------------------------------------------------------------------------------------|
| INFTITER   | Titer of infant/child's first reactive non-treponemal test for syphilis.                                                                  |
| AMIND      | American Indian/Alaskan Native:                                                                                                           |
| ASIAN      | Asian:                                                                                                                                    |
| BLACK      | Black:                                                                                                                                    |
| WHITE      | White:                                                                                                                                    |
| NAHAW      | Native Hawaiian or Other Pacific Islander:                                                                                                |
| RACEOTH    | Other Race:                                                                                                                               |
| RACEUNK    | Unknown Race:                                                                                                                             |
| MCOUNTRY   | Mother's country of residence.<br>(XX=Unknown)                                                                                            |
| REACTREP   | Did infant/child have reactive treponemal test?                                                                                           |
| RTDATE     | Date of infant/child's reactive treponemal test in YYYYMMDD format.<br>(99999999=Unknown)                                                 |
| STD IMPORT | Was case imported? Was disease acquired elsewhere? Indicates probable location of disease acquisition relative to reporting state values. |
| GRAVIDA    | Number of pregnancies (e.g. 01)<br>(99=Unknown)                                                                                           |
| PARA       | Number of live births (e.g. 03)<br>(99=Unknown)                                                                                           |
| PNCTRI     | Trimester of mother's first prenatal visit.                                                                                               |
| TESTVISA   | Did mother have non-treponemal or treponemal test at first prenatal visit?                                                                |

|          |                                                                                        |
|----------|----------------------------------------------------------------------------------------|
| TESTVISB | Did mother have non-treponemal or treponemal test at 28-32 weeks gestation?            |
| TESTVISC | Did mother have non-treponemal or treponemal test at delivery?                         |
| TREPDTA  | Date of mother's first treponemal test in YYYYMMDD format.<br>(99999999=Unknown)       |
| TESTTYPA | Test type of mother's first treponemal test.                                           |
| TREPRESA | Result of mother's first treponemal test.                                              |
| TREPDTB  | Date of mother's most recent treponemal test in YYYYMMDD format.<br>(99999999=Unknown) |
| TESTTYPB | Test type of mother's most recent treponemal test.                                     |
| TREPRESB | Result of mother's most recent treponemal test.                                        |
| HIVSTAT  | What was mother's HIV status during pregnancy?                                         |
| CLINSTAG | What clinical stage of syphilis did mother have during pregnancy?                      |

|          |                                                                                                |
|----------|------------------------------------------------------------------------------------------------|
| SURVSTAG | What surveillance stage of syphilis did mother have during pregnancy?                          |
| FIRSTDT  | Date of mother's first dose of benzathine penicillin in YYYYMMDD format.<br>(99999999=Unknown) |
| FIRSTDOS | When did mother receive her first dose of benzathine penicillin?                               |
| MOMTX    | What was mother's treatment?                                                                   |
| RESPAPP2 | Did mother have an appropriate serologic response?                                             |
| CLINNO   | No signs/asymptomatic?                                                                         |
| CLINLATA | Condyloma lata?                                                                                |
| CLINSNUF | Snuffles?                                                                                      |
| CLINRASH | Syphilitic skin rash?                                                                          |
| CLINHEPA | Hepatosplenomegaly?                                                                            |
| CLINJUAN | Jaundice/Hepatitis?                                                                            |
| CLINPARA | Pseudo paralysis?                                                                              |
| CLINEDEM | Edema?                                                                                         |
| CLINOTH  | Other signs of CS?                                                                             |
| CLINUNK  | Unknown signs of CS?                                                                           |
| CSFWBC   | Did the infant/child have a CSF WBC count or CSF protein test?                                 |

Maternal Local  
Record ID

Maternal  
Notification  
Reporting  
Jurisdiction

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC  
Priority  
(Legacy)

CDC  
Priority  
(New)

Value for case data: M=MMWR report

(Pad with a 9)

S01=State epidemiologist  
S02=State STD Program  
S03=State Chronic Disease Program  
S04-S99=Other state offices  
R01-R99=Regional or district offices  
001-999=County health depts (FIPS codes)  
L01-L99=Laboratories within state  
CD1=Historical records (prior to new format)  
CD2=Entered at CDC (based on phone reports)

10316=Syphilis (congenital)

2=0-52 Weeks  
9=Gestational Age Unknown (AGE field should be 999)

1=American Indian/Alaskan Native

2=Asian or Pacific Islander

3=Black

5=White

8=Other

9=Unknown

NOTE: Please use only one of the codes above if a single race was selected. If multiple races were selected, enter code 8=Other for Race and also select the appropriate race categories that apply in columns 238-244.

1=Hispanic/Latino

2=Non-Hispanic/Latino

9=Unknown

4=Date of first report to community health system

1=Confirmed, Probable, or Syphilitic stillbirth

2=Not a case

9=Unknown

1=Yes

2=No

9=Unknown

01=HIV Counseling and Testing Site  
02=STD clinic  
03=Drug Treatment  
04=Family Planning  
06=Tuberculosis clinic  
07=Other Health Department clinic  
08=Private Physician/HMO  
10=Hospital-Emergency Room; Urgent Care Facility  
11=Correctional Facility  
12=Laboratory  
13=Blood Bank  
14=Labor and Delivery  
15=Prenatal  
16=National Job Training Program  
17=School-based Clinic  
18=Mental Health Provider  
29=Hospital-Other  
66=Indian Health Service  
77=Military  
88=Other  
99=Unknown (if data not available)

20=Screening  
21=Self-referred  
22=Patient referred partner  
23=Health Department referred partner  
24= Cluster related  
88=Other  
99=Unknown

99999=Unknown (if data not available)

1=Single, never married  
2=Married  
3=Separated/Divorced  
4=Widow  
8=Other  
9=Unknown

0=No prenatal care  
9=Unknown

1=Reactive  
2=Nonreactive  
9=Unknown

1=Reactive  
2=Nonreactive  
9=Unknown

0=weakly reactive  
9999=Unknown

1=Alive  
2=Born alive, then died  
3=Stillborn  
9=Unknown

(If alive, pad with 99999999)  
(99999999=Unknown)

1=Yes  
2=No  
3=No test  
9=Unknown

1=Yes, positive  
2=Yes, negative  
3=No test  
4=No lesions and no tissue to test  
9=Unknown

1=Yes, changes consistent with CS  
2=Yes, no signs of CS  
3=No x-rays  
9=Unknown

1= Yes, reactive  
2=Yes, nonreactive  
3=No test  
9=unknown

1=Yes, with Aqueous or Procaine Penicillin for 10 days  
3=Yes, with Benzathine penicillin x 1  
4=Yes, with other treatment  
5=No treatment  
9=Unknown

1=Not a case  
2=Confirmed Case (laboratory confirmed identification of *T.pallidum*, e.g., darkfield or direct fluorescent antibody positive lesions)  
3=Syphilitic stillbirth  
4=Probable case (a case identified by the algorithm, which is not a confirmed case or syphilitic stillbirth)

41306

0=weakly reactive  
9999=Unknown

Note: All entries should be left justified (no preceding or trailing zeroes). Example: If titer is 1:64, enter 64; if titer is 1:1024, enter 1024.

0=weakly reactive

9999=Unknown

Note: All entries should be left justified (no preceding or trailing zeroes). Example: If titer is 1:64, enter 64; if titer is 1:1024, enter 1024.

If mother multi-racial: 1 = Yes; 2 = No; Otherwise pad with a 9.

If mother multi-racial: 1 = Yes; 2 = No; Otherwise pad with a 9.

If mother multi-racial: 1 = Yes; 2 = No; Otherwise pad with a 9.

If mother multi-racial: 1 = Yes; 2 = No; Otherwise pad with a 9.

If mother multi-racial: 1 = Yes; 2 = No; Otherwise pad with a 9.

If mother multi-racial: 1 = Yes; 2 = No; Otherwise pad with a 9.

If mother multi-racial: 1 = Yes; 2 = No; Otherwise pad with a 9.

1 = Yes

2 = No

3 = No test

9 = Unknown

N = Not an imported case

C = Yes, imported from another country

S = Yes, imported from another state

J = Yes, imported from another county/jurisdiction  
in the state

D = Yes, imported but not able to determine source  
state and/or country

U = Unknown

1 = 1st trimester

2 = 2nd trimester

3 = 3rd trimester

9 = Unknown

1 = Yes

2 = No

9 = Unknown

1 = Yes  
2 = No  
9 = Unknown

1 = Yes  
2 = No  
9 = Unknown

1 = EIA or CLIA  
2 = TP-PA  
3 = Other  
9 = Unknown

1 = Reactive  
2 = Nonreactive  
9 = Unknown

1 = EIA or CLIA  
2 = TP-PA  
3 = Other  
9 = Unknown

1 = Reactive  
2 = Nonreactive  
9 = Unknown

P = Positive  
E = Equivocal test  
X = Patient not tested  
N = Negative  
U = Unknown

1 = Primary  
2 = Secondary  
3 = Early latent  
4 = Late or late latent  
5 = Previously treated/serofast  
8 = Other  
9 = Unknown

1 = Primary  
2 = Secondary  
3 = Early latent  
4 = Late or late latent  
8 = Other  
9 = Unknown

1 = Before pregnancy  
2 = 1st trimester  
3 = 2nd trimester  
4 = 3rd trimester  
5 = No Treatment  
9 = Unknown

1 = 2.4 M units benzathine penicillin  
2 = 4.8 M units benzathine penicillin  
3 = 7.2 M units benzathine penicillin  
8 = Other  
9 = Unknown

1 = Yes, appropriate response  
2 = No, inappropriate response: evidence of treatment failure or reinfection  
3 = Response could not be determined from available non-treponemal titer information  
4 = Not enough time for titer to change

1 = Yes; Otherwise pad with a 9.  
1 = Yes; Otherwise pad with a 9.  
1 = Yes; Otherwise pad with a 9.  
1 = Yes; Otherwise pad with a 9.  
1 = Yes; Otherwise pad with a 9.  
1 = Yes; Otherwise pad with a 9.  
1 = Yes; Otherwise pad with a 9.  
1 = Yes; Otherwise pad with a 9.  
1 = Yes; Otherwise pad with a 9.  
1 = Yes; Otherwise pad with a 9.  
1 = Yes, CSF WBC count elevated  
2 = Yes, CSF protein elevated  
3 = Both tests elevated  
4 = Neither test elevated  
5 = No test  
9 = Unknown

Label/Short Name

Type of case

State lab isolate id

Phenotypic Test Method

Phenotypic Test Result

Genotypic Test Name

Genotypic Test Result

County of facility

State of facility

Travel Outside USA Prior to  
Illness Onset within  
Program Specific Timeframe

International Destination(s)  
of Recent Travel

Healthcare Outside USA

Country(ies) of Healthcare  
Outside USA

Gene Identifier

Previously Counted Case

Previously Reported State  
Case Number

WGS ID Number

## Description

Type of case (i.e., was case identified based on testing of a clinical specimen or screening specimen)

Lab isolate identifier from public health lab for mechanism testing

Phenotypic Test Name (phenotypic methods for carbapenemase production)

Result of Phenotypic test

Test performed to identify carbapenemase (molecular methods for resistance mechanism)

Result of test to identify carbapenemase

County of facility where specimen was collected

State of facility where specimen was collected

Did the patient travel internationally in the past 1 year from the date of specimen collection?

This data element is used to capture the names of the country(ies) outside of the United States the patient traveled to in the year prior to the date of specimen collection, if the patient has traveled outside of the United States during that time.

This data element is used to capture if the patient received healthcare outside of the United States in the year prior to the date of specimen collection.

This data element is used to capture the names of the country(ies) outside of the United States where the patient received healthcare in the year prior to the date of specimen collection, if the patient traveled outside of the United States during that time.

Gene identifier

Was patient previously counted as a colonization/screening case?

If patient was previously counted as colonization/screening case please provide related case ID(s)

NCBI SRA Accession number (SRX#) We would describe this as: The accession number generated by NCBI's Sequence Read Archive when sequence data are uploaded to NCBI. This provides both the sequence data and metadata on how the sample was sequenced.

|                                                                                                                                                                                   |                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| Value Set Code. Search in PHIN VADS using the following link<br>( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) | CDC<br>Priority |
| N/A                                                                                                                                                                               | P               |
| N/A                                                                                                                                                                               | P               |
| N/A                                                                                                                                                                               | P               |
| N/A                                                                                                                                                                               | P               |
| N/A                                                                                                                                                                               | P               |
| N/A                                                                                                                                                                               | P               |
| PHVS_County_FIPS_6-4                                                                                                                                                              | O               |
| PHVS_State_FIPS_5-2                                                                                                                                                               | O               |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P               |
| PHVS_Country_ISO_3166-1                                                                                                                                                           | P               |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P               |
| PHVS_Country_ISO_3166-1                                                                                                                                                           | P               |
| PHVS_GeneName_CP-CRE                                                                                                                                                              | P               |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             | P               |
| N/A                                                                                                                                                                               | P               |
| N/A                                                                                                                                                                               | P               |

| Label/Short Name                                                            | Description                                                                                                                                                                                                               |
|-----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| State lab isolate id                                                        | Lab isolate identifier from public health lab                                                                                                                                                                             |
| County of facility                                                          | County of facility where specimen was collected                                                                                                                                                                           |
| State of facility                                                           | State of facility where specimen was collected                                                                                                                                                                            |
| Travel Outside USA Prior to Illness Onset within Program Specific Timeframe | Did the patient travel internationally in the year prior to the date of specimen collection?                                                                                                                              |
| International Destination(s) of Recent Travel                               | Names of the country(ies) outside of the United States the patient traveled to in the year prior to the date of specimen collection, if the patient has traveled outside of the United States during that time.           |
| Healthcare Outside USA                                                      | Patient received healthcare outside of the United States in the year prior to the date of specimen collection.                                                                                                            |
| Country(ies) of Healthcare Outside USA                                      | Names of the country(ies) outside of the United States where the patient received healthcare in the year prior to the date of specimen collection, if the patient traveled outside of the United States during that time. |
| Gene Identifier                                                             | Gene identifier                                                                                                                                                                                                           |
| Previously Counted Case                                                     | Was patient previously counted as a colonization/screening case?                                                                                                                                                          |
| Previously Reported State Case Number                                       | If patient was previously counted as colonization/screening case please provide related case ID(s)                                                                                                                        |
| WGS ID Number                                                               | Genomic sequencing ID number                                                                                                                                                                                              |
| Tracheostomy Tube at Specimen Collection                                    | Did patient have a tracheostomy tube at the time of specimen collection?                                                                                                                                                  |
| Ventilator Use at Specimen Collection                                       | Was patient on a ventilator at the time of specimen collection?                                                                                                                                                           |
| Long-term Care Resident                                                     | Did the patient have a stay in a long-term care facility in the 90 days before specimen collection date?                                                                                                                  |
| Type of Long-term Care Facility                                             | If patient had a stay in a long-term care facility in the 90 days before specimen collection date, indicate the type of long-term care facility.                                                                          |
| Healthcare Outside Resident State                                           | Indicate if the patient received overnight healthcare within the United States, but outside of the patient's resident state in the year prior to the date of specimen collection.                                         |
| Type of Location Where Specimen Collected                                   | Indicate the physical location type of the patient when the specimen was collected                                                                                                                                        |
| Infection with Another MDRO                                                 | Does the patient have infection or colonization with another MDRO?                                                                                                                                                        |
| Co-infection Type                                                           | If patient has infection or colonization with another MDRO, indicate the MDRO.                                                                                                                                            |
| Date Arrived at Healthcare Facility                                         | Start date of visit/admission                                                                                                                                                                                             |
| Date Departed Healthcare Facility                                           | End date of visit/admission                                                                                                                                                                                               |

| Value Set Code. Search in PHIN VADS using the following link ( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) | CDC Priority (Legacy) | CDC Priority (New) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------|
| N/A                                                                                                                                                                            |                       | 1                  |
| PHVS_County_FIPS_6-4                                                                                                                                                           |                       | 1                  |
| PHVS_State_FIPS_5-2                                                                                                                                                            |                       | 1                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| PHVS_Country_ISO_3166-1                                                                                                                                                        |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| PHVS_Country_ISO_3166-1                                                                                                                                                        |                       | 2                  |
| TBD                                                                                                                                                                            |                       | 1                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 1                  |
| N/A                                                                                                                                                                            |                       | 1                  |
| N/A                                                                                                                                                                            |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| TBD                                                                                                                                                                            |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| TBD                                                                                                                                                                            |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| TBD                                                                                                                                                                            |                       | 2                  |
| N/A                                                                                                                                                                            |                       | 2                  |
| N/A                                                                                                                                                                            |                       | 2                  |

| Label/Short Name                                                 | Description                                                                                         |
|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|
| PulseNet ID                                                      | State lab ID submitted to PulseNet                                                                  |
| Date Case Report Form Completed                                  | Date case report form was completed                                                                 |
| Patient Or Surrogate Able To Be Interviewed                      | Was patient or surrogate able to be interviewed?                                                    |
| Healthcare Setting Exposure Type                                 | Type of exposure to healthcare setting                                                              |
| Clinical Syndrome                                                | Clinical Syndrome is the type of clinical presentation the case had.                                |
| Obstetric Delivery Method                                        | Type of delivery                                                                                    |
| Gestational Age                                                  | Gestational age (weeks)                                                                             |
| Birth Weight                                                     | Birth weight (in grams)                                                                             |
| Antibiotics Given to Mother                                      | Were intrapartum antibiotics given to mother?                                                       |
| Treatment Received                                               | Was treatment received for this condition?                                                          |
| Antimicrobial Susceptibility Testing Performed At The Laboratory | Was antimicrobial sensitivity testing done at the laboratory?                                       |
| Hospitalization At Onset                                         | Was patient hospitalized at time of illness onset?                                                  |
| Birth Multiplicity                                               | Was infant single, multiple or unknown number of births?                                            |
| Medication By Mouth Or Feeding Tube                              | Did patient receive any medication by mouth or feeding tube in the 10 days prior to illness onset?  |
| Steroids Given                                                   | Has patient ever been treated with steroids                                                         |
| Gastric Acid Suppressing Medication Given                        | Did infant receive gastric acid suppressing medication in the 10 days prior to illness onset        |
| Infant Feeding Method                                            | How was infant fed 10 days prior to illness onset?                                                  |
| Specify Feeding Tube Type                                        | If infant was fed via feeding tube, specify tube type                                               |
| Fed Breast Milk                                                  | In the 10 days before illness began, was infant ever fed breast milk?                               |
| Breast Milk Source                                               | If yes, what source of breast milk?                                                                 |
| Exclusively Breast Fed                                           | Was infant exclusively breast fed?                                                                  |
| Consumed Expressed Breast Milk                                   | Was expressed breast milk consumed (i.e., pumped and fed through bottle or tube)?                   |
| Combined Milk                                                    | If yes, was pumped milk from multiple pumping sessions ever combined and then stored for later use? |
| Consumed Liquid Formula                                          | Did infant consume liquid formula in the 10 days before illness began?                              |
| Consumed Solid Food                                              | Did infant consume any solid foods, including cereal, in the 10 days before illness began?          |
| Specify Solid Food Type                                          | If yes, specify type of solid food                                                                  |
| Specify Liquid Formula                                           | If infant cereal was consumed, type of liquid used for preparing infant cereal                      |
| Formula Prepared With Water                                      | Was water used to prepare infant formula                                                            |
| Formula Water Type                                               | Type of water used for preparing infant formula                                                     |
| Formula Water Boiled                                             | Was water boiled and cooled before adding to formula                                                |
| Formula Water Mix Method                                         | How were formula and water mixed                                                                    |

|                                       |                                                                                                                             |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| Breast Milk or Formula Additive       | Was anything ever added to breast milk or formula (besides water) during the 10 days before illness                         |
| Formula Preparation Frequency         | What frequency was formula prepared                                                                                         |
| Formula Storage Location              | Where was prepared formula stored                                                                                           |
| Maximum Refrigerated Storage Time     | Maximum storage time of prepared, refrigerated formula                                                                      |
| Maximum Room Temperature Storage Time | Maximum storage time of prepared, room temperature formula                                                                  |
| Formula Temperature                   | What temperature was formula at time of feeding                                                                             |
| Formula Left In Crib                  | Was prepared feed ever left in a crib with infant overnight?                                                                |
| Formula Reused                        | Was a partially consumed bottle that was at room temperature for more than 2 hours ever saved and given to the infant later |
| Formula Lid Surface Contact           | Was the lid of the formula container ever placed on the counter, in the sink, or on another surface                         |
| Formula Scoop Surface Contact         | Was the formula scoop ever placed on the counter, in the sink, or on another surface                                        |
| Equipment Disassembled                | Were bottles, nipples, and rings always completely dissembled before cleaning                                               |
| Bottle Cleaned                        | Were bottles cleaned after each use                                                                                         |
| Bottle Cleaning Method                | How were bottles cleaned                                                                                                    |
| Bottle Scrub Method                   | Were bottles scrubbed using                                                                                                 |
| Bottle Cleaned With Soap              | Was soap used when cleaning bottles                                                                                         |
| Bottle Drying Method                  | How were bottle parts dried                                                                                                 |
| Equipment Sanitized                   | Were bottles, nipples, and/or rings sanitized                                                                               |
| Equipment Sanitized Frequency         | If yes, how often were they sanitized                                                                                       |
| Equipment Sanitized Method            | How were parts sanitized                                                                                                    |
| Pump Type                             | What type of pump was used                                                                                                  |
| Pump Disassembled                     | Were flanges, valves, membranes, and connector tubing always completely disassembled before cleaning                        |
| Pump Cleaned                          | Was the pump kit, not including tubing, cleaned after each use                                                              |
| Pump Cleaning Frequency               | If no, how many times was it used before being cleaned                                                                      |
| Pump Rinsed                           | Was kit rinsed between uses                                                                                                 |
| Pump Storage Location                 | Where was unwashed kit stored between uses                                                                                  |
| Pump Cleaning Method                  | How were pump and parts cleaned                                                                                             |
| Pump Scrubbing Method                 | Were pump and parts scrubbed using                                                                                          |
| Pump Cleaned With Soap                | Was soap always used when washing pump kit and parts                                                                        |
| Pump Drying Method                    | How were pump parts dried                                                                                                   |
| Pump Sanitized                        | Was pump kit ever sanitized                                                                                                 |
| Pump Sanitized Frequency              | If yes, how often were they sanitized                                                                                       |
| Pump Sanitized Method                 | How were parts sanitized                                                                                                    |
| Pump Reassembled When Damp            | Was clean pump kit ever reassembled while still damp                                                                        |
| Product Name                          | Complete product name (including brand, type, and variety)                                                                  |

**Product Manufacturer**

**Product Type**

**Product Size**

**Lot Number**

**Use By Date**

**Date First Consumed**

**Date Last Consumed**

**Dates Consumed Unknown**

**Antibiotics With Intermediate  
Resistance**

**Antibiotics With Complete  
Resistance**

**Product manufacturer**

**Type of product**

**Size of container**

**Lot number(s), if known**

**Use by Date**

**Date first consumed**

**Date last consumed**

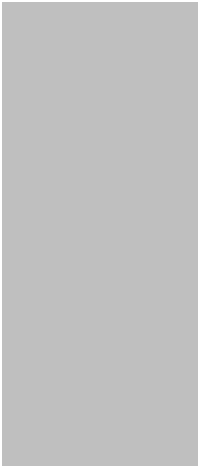
**Dates Consumed Unknown**

**If yes, antibiotics with intermediate resistance:**

**If yes, antibiotics with complete resistance:**

| Value Set Code. Search in PHIN VADS using the following link ( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) | CDC Priority (Legacy) | CDC Priority (New) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------|
| N/A                                                                                                                                                                            |                       | 1                  |
| N/A                                                                                                                                                                            |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| TBD                                                                                                                                                                            |                       | 2                  |
| TBD                                                                                                                                                                            |                       | 1                  |
| TBD                                                                                                                                                                            |                       | 2                  |
| N/A                                                                                                                                                                            |                       | 1                  |
| N/A                                                                                                                                                                            |                       | 2                  |
| TBD                                                                                                                                                                            |                       | 3                  |
| TBD                                                                                                                                                                            |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 3                  |
| TBD                                                                                                                                                                            |                       | 2                  |
| TBD                                                                                                                                                                            |                       | 3                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 3                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 3                  |
| TBD                                                                                                                                                                            |                       | 1                  |
| TBD                                                                                                                                                                            |                       | 1                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 1                  |
| TBD                                                                                                                                                                            |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 1                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 1                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 1                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 1                  |
| TBD                                                                                                                                                                            |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 1                  |
|                                                                                                                                                                                |                       | 1                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                          |                       | 1                  |
| TBD                                                                                                                                                                            |                       | 3                  |

|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | 2 |
| TBD                   | 3 |
| TBD                   | 3 |
| TBD                   | 1 |
| TBD                   | 1 |
| TBD                   | 3 |
| PHVS_YesNoUnknown_CDC | 3 |
| PHVS_YesNoUnknown_CDC | 3 |
| PHVS_YesNoUnknown_CDC | 3 |
| PHVS_YesNoUnknown_CDC | 3 |
| PHVS_YesNoUnknown_CDC | 2 |
| PHVS_YesNoUnknown_CDC | 2 |
| TBD                   | 3 |
| TBD                   | 2 |
| PHVS_YesNoUnknown_CDC | 2 |
| TBD                   | 2 |
| PHVS_YesNoUnknown_CDC | 2 |
| TBD                   | 2 |
| TBD                   | 3 |
| TBD                   | 3 |
| PHVS_YesNoUnknown_CDC | 2 |
| PHVS_YesNoUnknown_CDC | 2 |
| TBD                   | 2 |
| PHVS_YesNoUnknown_CDC | 2 |
| TBD                   | 3 |
| TBD                   | 2 |
| PHVS_YesNoUnknown_CDC | 2 |
| PHVS_YesNoUnknown_CDC | 2 |
| TBD                   | 3 |
| PHVS_YesNoUnknown_CDC | 3 |
| TBD                   | 3 |
| TBD                   | 3 |
| PHVS_YesNoUnknown_CDC | 3 |
| TBD                   | 1 |

|     |                                                                                    |   |
|-----|------------------------------------------------------------------------------------|---|
| TBD |  | 1 |
| TBD |                                                                                    | 1 |
| TBD |                                                                                    | 2 |
| N/A |                                                                                    | 1 |
| N/A |                                                                                    | 1 |
| N/A |                                                                                    | 1 |
| N/A |                                                                                    | 1 |
| TBD |                                                                                    | 1 |
| N/A |                                                                                    | 3 |
| N/A |                                                                                    | 2 |

Label/Short Name

Animal Contact Questions Indicator

Animal Contact Indicator

Animal Type Code(s)

Animal Type Other

Amphibian Other

Reptile Other

Mammal Other

Animal Contact Location

Acquired New Pet

Applicable Incubation Period

Associated with Daycare Indicator

Day Care Attendee

Day Care Worker

Live with Day Care Attendee

Day Care Type

Day Care Facility Name

Food Prepared at this Daycare

Diapered Infants at this Daycare

Drinking Water Exposure Indicator

Home Tap Water Source Code

Home Well Treatment Code

Home Tap Water Source Other

School/Work Tap Water Source Code

School/Work Well Treatment Code

School/Work Tap Water Source

Other

Drink Untreated Water 14 days Prior  
to Onset

Food Handler

Food Handler after Illness Onset

Food Handler Last Worked Date

Food Handler Location

Recreational Water Exposure  
Questions Indicator

Recreational Water Exposure 14  
Days Prior to Onset

Recreational Water Exposure Type  
Code(s)

Recreational Water Exposure Type  
Other

Swimming Pool Type Code(s)

Swimming Pool Type Other

Recreational Water Location Name

Related Case Indicator  
Patient Knows of Similarly Ill Persons

Health Department Investigated

Other Related Cases  
Travel Questions Indicator  
Travel Prior To Onset  
Incubation Period  
Travel Purpose Code(s)  
Travel Purpose Other  
Destination 1 Type:  
(Domestic) Destination 1:  
(International) Destination 1  
Mode of Travel: (1)  
Date Of Arrival (1)  
Date of Departure (1)  
Destination 2 Type  
(Domestic) Destination 2  
(International) Destination 2  
Mode of Travel: (2)  
Date of Arrival: (2)  
Date of Departure (2)  
Destination 3 Type:  
(Domestic) Destination 3:  
(International) Destination 3  
Mode of Travel: (3)  
Date of Arrival: (3)  
Date of Departure (3)  
Other Destination Txt  
Reporting Lab Name  
Reporting Lab CLIA Number

Local record ID (case ID)

Filler Order Number  
Ordered Test Name

Date of Specimen Collection  
Specimen Site

Specimen Number  
Specimen Source

## Specimen Details

Date Sample Received at Lab

Sample Analyzed date

Lab Report Date

Report Status

Resulted Test Name

Numeric Result

Result Units

Coded Result Value

Organism Name

Lab Result Text Value

Result Status

Interpretation Flag

Reference Range From

Reference Range To

Test Method

Lab Result Comments

Date received in state public health  
lab

Lab Test Coded Comments

Genotyping/ Subtyping

Genotyping Sent Date

Genotype/Subtype location

Genotype

Subtype

Track Isolate

Patient status at specimen collection

Isolate received in state public health  
lab

Reason isolate not received

Reason isolate not received (Other)

Date received in state public health  
lab

State public health lab isolate id  
number

Case confirmed at state public health  
lab

AgClinic

AgClinicTestType

AgeMnth

AgeYr

AgSphl

AgSphlTestType

BloodyDiarr

Diarrhea

DtAdmit2

DtDisch2

DtEntered

DtRcvd

DtRptComp

DtSpec

DtUSDepart

DtUSReturn

EforsNum

Fever

HospTrans

Immigrate

Interview

LabName

LocalID

OtherCdcTest

OtherClinicTest

OtherClinicTestType

OtherSphlTest

OtherSphlTestType

OutbrkType

PatID

PcrCdc

PcrClinic

PcrClinicTestType

PcrSphl

PersonID

ResultID

RptComp

SentCDC

SLabsID

SpeciesClinic  
SpeciesSphl  
SpecSite  
StLabRcvd

TravelDest  
TravelInt  
Specify Different Exposure Window

CryptoNet ID

WGS ID Number  
Travel State  
International Destination(s) of  
Recent Travel  
Date of Arrival to Travel Destination

Date of Departure from Travel  
Destination  
Reason for travel related to current  
illness  
Travel Outside USA Prior to Illness  
Onset within Program Specific  
Timeframe

Did The Case Travel Domestically  
Prior To Illness Onset?

Specify Different Travel Exposure  
Window

## Description

If contact with animal, then display the following questions

Did patient come in contact with an animal?

Type of animal: (MULTISELECT)

If "Other," please specify other type of animal:

If "Other Amphibian," please specify other type of amphibian:

If "Other Reptile," please specify other type of reptile:

If "Other Mammal," please specify other type of mammal:

Name or Location of Animal Contact:

Did the patient acquire a pet prior to onset of illness?

Applicable incubation period for this illness is

If Patient associated with a day care center:

Attend a day care center?

Work at a day care center?

Live with a day care center attendee?

What type of day care facility?

What is the name of the day care facility?

Is food prepared at this facility?

Does this facility care for diapered persons?

If patient has had Drinking Water exposure, then display the following questions

What is the source of tap water at home?

If "Private Well," how was the well water treated at home?

If "Other," specify other source of tap water at home:

What is the source of tap water at school/work?

If "Private Well," how was the well water treated at school/work?

If "Other," specify other source of tap water at school/work:

Did patient drink untreated water 14 days prior to onset of illness?

If patient is a Food Handler, then display the following questions

Did patient work as a food handler after onset of illness?

What was the last date worked as a food handler after onset of illness?

Where was patient a food handler?

If patient has had recreational water exposure, then display the following

Was there recreational water exposure in the 14 days prior to illness?

What was the recreational water exposure type? (MULTISELECT)

If "Other," please specify other recreational water exposure type:

If "Swimming Pool," please specify swimming pool type: (MULTISELECT)

If "Other," please specify other swimming pool type:

Name or location of water exposure:

If related cases are associated to this case, then display the following questions

Does the patient know of any similarly ill persons?

If "Yes," did the health department collect contact information about other similarly ill persons and investigate further?

Are there other cases related to this one?

If patient has traveled, then display the following questions

Did the patient travel prior to onset of illness?

Applicable incubation period for this illness is 14 days

What was the purpose of the travel? (MULTISELECT)

If "Other," please specify other purpose of travel:

Destination 1 Type:

(Domestic) Destination 1:

(International) Destination 1

Mode of Travel: (1)

Date of Arrival: (1)

Date of Departure (1)

Destination 2 Type

(Domestic) Destination 2

(International) Destination 2

Mode of Travel: (2)

Date of Arrival: (2)

Date of Departure (2)

Destination 3 Type:

(Domestic) Destination 3:

(International) Destination 3

Mode of Travel: (3)

Date of Arrival: (3)

Date of Departure (3)

If more than 3 destinations, specify details here:

Name of Laboratory that reported test result.

CLIA (Clinical Laboratory Improvement Act) identifier for the laboratory that performed the test.

Sending system-assigned local ID of the case investigation with which the subject is associated. This field has been added to provide the mapping to the case/investigation to which this lab result is associated. This field should appear exactly as it ap

A laboratory generated number that identifies the test/order instance.

Ordered Test Name is the lab test ordered by the physician. It will always be included in an ELR, but there are many instances in which the user entering manual reports will not have access to this information.

The date the specimen was collected.

This indicates the physical location, of the subject, where the specimen originated. Examples include: Right Internal Jugular, Left Arm, Buttock, Right Eye, etc.

A laboratory generated number that identifies the specimen related to this test.

The medium from which the specimen originated. Examples include whole blood, saliva, urine, etc.

Specimen details if specimen information entered as text.

Date Sample Received at Lab (accession date).

The date and time the sample was analyzed by the laboratory.

Date result sent from Reporting Laboratory.

The status of the lab report.

The lab test that was run on the specimen.

Results expressed as numeric value/quantitative result.

The unit of measure for numeric result value.

Coded qualitative result value.

The organism name as a test result. This element is used when the result was reported as an organism.

Textual result value, used if result is neither numeric nor coded.

The Result Status is the degree of completion of the lab test.

The interpretation flag identifies a result that is not typical as well as how it's not typical. Examples: Susceptible, Resistant, Normal, Above upper panic limits, below absolute low.

The reference range from value allows the user to enter the value on one end of a expected range of results for the test. This is used mostly for quantitative results.

The reference range to value allows the user to enter the value on the other end of a valid range of results for the test. This is used mostly for quantitative results.

The technique or method used to perform the test and obtain the test results. Examples: Serum Neutralization, Titration, dipstick, test strip, anaerobic culture.

Comments having to do specifically with the lab result test. These are the comments from the NTE segment if the result was originally an Electronic Laboratory Report.

Date the isolate was received in state public health laboratory.

Explanation for missing result (e.g., clotting, quantity not sufficient, etc.)

Indicate whether the specimens were genotyped and/or subtyped

If the specimen was sent to the CDC for genotyping, date on which the specimens were sent.

Indicate where Genotype and/or subtype testing was performed

If the specimen was sent for genotype identification, indicate the genotype

If the specimen was sent for subtype identification, indicate the subtype

Track Isolate functionality indicator

Patient status at specimen collection

Isolate received in state public health lab

Reason isolate not received

Reason isolate not received (Other)

Date received in state public health lab

State public health lab isolate id number

Case confirmed at state public health lab

What was the result of specimen testing using an antigen-based test (e.g. EIA or lateral flow) at a clinical laboratory?

Name of antigen-based test used at clinical laboratory

Age of case-patient in months if patient is <1yr

Age of case-patient in years

What was the result of specimen testing using an antigen-based test (e.g. EIA or lateral flow) at a state public health laboratory?

Name of antigen-based test used at state public health laboratory

Did the case-patient have bloody diarrhea (self reported) during this illness?

Did the case-patient have diarrhea (self-reported) during this illness?

Date of hospital admission for second hospitalization for this illness

Date of hospital discharge for second hospitalization for this illness

Date case was entered into site's database

Date case-patient's specimen was received in laboratory for initial testing

Date case report form was completed

Case-patient's specimen collection date

If case-patient traveled internationally, date of departure from the U.S.

If case-patient traveled internationally, date of return to the U.S.

CDC FDOSS outbreak ID number

Did the case-patient have fever (self-reported) during this illness?

If case-patient was hospitalized, was s/he transferred to another hospital?

Did case-patient immigrate to the U.S.? (within 15 days of illness onset)

Was the case-patient interviewed by public health (i.e. state or local health department) ?

Name of submitting laboratory

Case-patient's medical record number

What was the result of specimen testing using another test at CDC?

What was the result of specimen testing using another test at a clinical laboratory?

Name of other test used at a clinical laboratory

What was the result of specimen testing using another test at a state public health laboratory?

Name of other test used at a state public health laboratory

Type of outbreak that the case-patient was part of

Case-patient identification number

What was the result of specimen testing for diagnosis using PCR at CDC? (Do not enter PCR results if PCR was performed for speciation or subtyping).

What was the result of specimen testing using PCR at a clinical laboratory? (where goal of testing is primary detection not subtyping or speciation)

Name of PCR assay used

What was the result of specimen testing for diagnosis using PCR at the state public health laboratory? (Do not enter PCR results if PCR was performed for speciation or subtyping).

Unique identification number for person or patient

Unique identifier for laboratory result

Is all of the information for this case complete?

Was specimen or isolate forwarded to CDC for testing or confirmation?

State lab identification number

What was the species result at clinical lab?

What was the species result at SPHL?

Case patient's specimen collection source

Was the isolate sent to a state public health laboratory? (Answer 'Yes' if it was sent to any state lab, even if it was sent to a lab outside of the case's state of residence)

If case-patient traveled internationally, to where did they travel?

Did the case patient travel internationally? (within 15 days of onset)

If the epidemiologic exposure window used by the jurisdiction is different from that stated in the exposure questions, specify the time interval in days here. Otherwise, leave blank.

Unique CryptoNet ID (formed by concatenating [Case Year]-[State Lab ID]-[Specimen Type]-[Reporting State]-[Reporting Country]) where Specimen Type is: ES for Environmental, HS for Human, or AS for Animal.

Whole Genome Sequencing (WGS) ID Number

Domestic destination, state(s) traveled to

International destination or countries the patient traveled to

Date of arrival to travel destination

Date of departure from travel destination

Reason for travel related to current illness

Did the case patient travel internationally?

Indicates whether the case traveled domestically prior to illness onset and within program specific timeframe

If the travel exposure window used by the jurisdiction is different from that stated in the travel exposure questions, specify the time interval in days here. Otherwise, leave blank.

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

Yes No Indicator (HL7)

Yes No Unknown (YNU)

Animal Type (FDD)

Yes No Unknown (YNU)

Yes No Indicator (HL7)

Yes No Unknown (YNU)

Yes No Unknown (YNU)

Yes No Unknown (YNU)

Day CareType (FDD)

Yes No Unknown (YNU)

Yes No Unknown (YNU)

Yes No Indicator (HL7)

Tap Water Source (FDD)

Well Water Treatment (FDD)

Tap Water Source (FDD)

Well Water Treatment (FDD)

Yes No Unknown (YNU)

Yes No Indicator (HL7)

Yes No Unknown (YNU)

Yes No Indicator (HL7)

Yes No Unknown (YNU)

Recreational Water (FDD)

Swimming Pool Type (FDD)

Yes No Indicator (HL7)  
Yes No Unknown (YNU)

Yes No Unknown (YNU)

Other Related Cases  
Yes No Indicator (HL7)  
Yes No Unknown (YNU)

Travel Purpose

Travel Destination Type  
State  
Country  
Travel Mode

Travel Destination Type  
State  
Country  
Travel Mode

Travel Destination Type  
State  
Country  
Travel Mode

Ordered Test

Specimen

Specimen

Result Status (HL7)  
Lab Test Result Name (FDD)

Units Of Measure  
Lab Test Result Qualitative  
Microorganism (FDD)

Observation Result Status (HL7)  
Abnormal Flag (HL7)

Observation Method

Missing Lab Result Reason  
Yes No Unknown (YNU)

Yes No Indicator (HL7)  
Patient Location Status at Specimen Collection

Yes No Unknown (YNU)

Isolate Not Received Reason

Yes No Unknown (YNU)

N/A

P

N/A

N/A  
PHVS\_State\_FIPS\_5-2  
PHVS\_Country\_ISO\_3166-1

N/A

N/A

PHVS\_TravelPurpose\_FDD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

N/A



CDC Priority (New)

1

1

3

3

3

3

3

2

2

2

Label/Short Name

Cabbage

Interview Status

Travel Destination Type

Travel Mode

Travel Purpose

Date of departure

Date of arrival

Destination code

Destination description

Person Knows of Similarly Ill Persons

Diarrhea Indicator

Max Stools per 24 Hrs

Weight Loss

Baseline Weight

Baseline Weight Units

Weight Lost

Weight Lost Units

Fever

Temperature

Temperature Units

Cyclosporiasis Symptom Code(s)

Cyclosporiasis Symptoms Other

Cyclosporiasis Confirmed By CDC

Treated For Cyclosporiasis

Sulfa Allergy

Fresh Berries Code(s)

Fresh Berries Other

Fresh Herbs Code(s)

Fresh Herbs Other

Lettuce Last 14 Days Code(s)

Lettuce Last 14 Days Other

Produce Last 14 Days Code(s)

Produce Last 14 Days Other

Fruit Other Than Berries Specify

Attend Events 14 Days Prior to Onset

Event Specify

Event Date

Eat at Restaurant 14 Days Prior to  
Onset

Restaurant(s) Specify

Reporting Lab Name

Reporting Lab CLIA Number

Local record ID (case ID)

Filler Order Number

Ordered Test Name

Date of Specimen Collection

Specimen Site

Specimen Number

Specimen Source

Specimen Details

Date Sample Received at Lab

Sample Analyzed date

Lab Report Date

Report Status

Resulted Test Name

Numeric Result

Result Units

Coded Result Value

Organism Name

Lab Result Text Value

Result Status

Interpretation Flag

Reference Range From

Reference Range To

Test Method

Lab Result Comments

Date received in state public health  
lab

Lab Test Coded Comments  
Sent to CDC for Genotyping  
Genotyping Sent Date

Sent For Strain ID  
Strain Type  
Track Isolate  
Patient status at specimen collection

Isolate received in state public health  
lab

Reason isolate not received  
Reason isolate not received (Other)  
Date received in state public health  
lab

State public health lab isolate id  
number

Case confirmed at state public health  
lab

AgClinic

AgClinicTestType  
AgeMnth  
AgeYr  
AgSphl

AgSphlTestType

BloodyDiarr  
Diarrhea  
DtAdmit2  
DtDisch2  
DtEntered  
DtRcvd  
DtRptComp  
DtSpec  
DtUSDepart  
DtUSReturn  
EforsNum  
Fever  
HospTrans  
Immigrate  
Interview

LabName  
LocalID

OtherCdcTest

OtherClinicTest

OtherClinicTestType

OtherSphlTest

OtherSphlTestType

OutbrkType

PatID

PcrCdc

PcrClinic

PcrClinicTestType

PcrSphl

PersonID

ResultID

RptComp

SentCDC

SLabsID

SpecSite

StLabRcvd

TravelDest

TravelInt

Travel

Travel State

Medication Administered

Performing Laboratory Type

Other Organism from Specimen

Specify Different Travel Exposure  
Window

Did The Case Travel Domestically  
Prior To Illness Onset?

Specify Different Exposure Window

Reason for travel related to current  
illness

Fresh Lettuce Packaging

## Description

Was fresh cabbage consumed in the 14 days prior to onset of illness?

Interview Status

Travel Destination Type

Travel Mode

Purpose of Travel

Departure Date

Arrival Date

FIPS code assigned to city/state/country

Name of city/state/country

Does the patient know of any similarly ill persons?

Did the patient have diarrhea?

If "Yes," please specify maximum number of stools per 24 hours:

Did patient experience weight loss?

If "Yes," please specify baseline weight:

specify baseline weight in lbs or kgs

Specify how much weight was lost:

Specify weight loss in lbs or kgs

Did patient have a fever?

If "Yes," please specify temperature (observation includes units)

Specify temperature in fahrenheit or centigrade

Did the patient have any of the following signs or symptoms of Cyclosporiasis?  
(MULTISELECT)

If "Other," please specify other signs or symptoms of Cyclosporiasis:

Was the case confirmed at the CDC lab?

Was the patient treated for Cyclosporiasis?

Does the patient have a sulfa allergy?

What fresh berries were eaten in the 14 days prior to onset of illness? (MULTISELECT)

If "Other," please specify other type of fresh berries:

What fresh herbs were eaten in the 14 days prior to onset of illness? (MULTISELECT)

If "Other," please specify other type of fresh herbs:

What fresh lettuce was eaten in the 14 days prior to onset of illness? (MULTISELECT)

If "Other," please specify other type of fresh lettuce:

What other types of fresh produce were eaten in the 14 days prior to onset of illness?  
(MULTISELECT)

If "Other," please specify other type of fresh produce:

If "Fruit, other than berries," please specify type of fruit other than berries:

Did patient attend any events in the 14 days prior to onset of illness?

If "Yes," please specify the event:

Date of event:

Did patient eat at restaurant(s) in the 14 days prior to onset of illness?

If "Yes," please specify the name of the restaurant(s):

Name of Laboratory that reported test result.

CLIA (Clinical Laboratory Improvement Act) identifier for the laboratory that performed the test.

Sending system-assigned local ID of the case investigation with which the subject is associated. This field has been added to provide the mapping to the case/investigation to which this lab result is associated. This field should appear exactly as it appears in OBR-3 of the Case Notification.

A laboratory generated number that identifies the test/order instance.

Ordered Test Name is the lab test ordered by the physician. It will always be included in an ELR, but there are many instances in which the user entering manual reports will not have access to this information.

The date the specimen was collected.

This indicates the physical location, of the subject, where the specimen originated. Examples include: Right Internal Jugular, Left Arm, Buttock, Right Eye, etc.

A laboratory generated number that identifies the specimen related to this test.

The medium from which the specimen originated. Examples include whole blood, saliva, urine, etc.

Specimen details if specimen information entered as text.

Date Sample Received at Lab (accession date).

The date and time the sample was analyzed by the laboratory.

Date result sent from Reporting Laboratory.

The status of the lab report.

The lab test that was run on the specimen.

Results expressed as numeric value/quantitative result.

The unit of measure for numeric result value.

Coded qualitative result value (e.g., Positive, Negative).

The organism name as a test result. This element is used when the result was reported as an organism.

Textual result value, used if result is neither numeric nor coded.

The Result Status is the degree of completion of the lab test.

The interpretation flag identifies a result that is not typical as well as how it's not typical. Examples: Susceptible, Resistant, Normal, Above upper panic limits, below absolute low.

The reference range from value allows the user to enter the value on one end of a expected range of results for the test. This is used mostly for quantitative results.

The reference range to value allows the user to enter the value on the other end of a valid range of results for the test. This is used mostly for quantitative results.

The technique or method used to perform the test and obtain the test results.

Examples: Serum Neutralization, Titration, dipstick, test strip, anaerobic culture.

Comments having to do specifically with the lab result test. These are the comments from the NTE segment if the result was originally an Electronic Laboratory Report.

Date the isolate was received in state public health laboratory.

Explanation for missing result (e.g., clotting, quantity not sufficient, etc.)

Indicate whether the specimens were sent to CDC for genotyping.

If the specimen was sent to the CDC for genotyping, date on which the specimens were sent.

Indicate whether the specimen was sent for strain identification.

If the specimen was sent for strain identification, indicate the strain.

Track Isolate functionality indicator

Patient status at specimen collection

Isolate received in state public health lab

Reason isolate not received

Reason isolate not received (Other)

Date received in state public health lab

State public health lab isolate id number

Case confirmed at state public health lab

What was the result of specimen testing using an antigen-based test (e.g. EIA or lateral flow) at a clinical laboratory?

Name of antigen-based test used at clinical laboratory

Age of case-patient in months if patient is <1yr

Age of case-patient in years

What was the result of specimen testing using an antigen-based test (e.g. EIA or lateral flow) at a state public health laboratory? Results from rapid card testing or EIA would be entered here.

Name of antigen-based test used at state public health laboratory

Did the case-patient have bloody diarrhea (self reported) during this illness?

Did the case-patient have diarrhea (self-reported) during this illness?

Date of hospital admission for second hospitalization for this illness

Date of hospital discharge for second hospitalization for this illness

Date case was entered into site's database

Date case-patient's specimen was received in laboratory for initial testing

Date case report form was completed

Case-patient's specimen collection date

If case-patient traveled internationally, date of departure from the U.S.

If case-patient traveled internationally, date of return to the U.S.

CDC FDOSS outbreak ID number

Did the case-patient have fever (self-reported) during this illness?

If case-patient was hospitalized, was s/he transferred to another hospital?

Did case-patient immigrate to the U.S.? (within 15 days of illness onset)

Was the case-patient interviewed by public health (i.e. state or local health department) ?

Name of submitting laboratory

Ccase-patient's medical record number

For other pathogens: What was the result of specimen testing using another test at CDC? Results from DFA, IFA or other tests would be entered here.

What was the result of specimen testing using another test at a clinical laboratory? Results from DFA, IFA or other tests would be entered here.

Name of other test used at a clinical laboratory

What was the result of specimen testing using another test at a state public health laboratory? Results from DFA, IFA or other tests would be entered here.

Name of other test used at a state public health laboratory

Type of outbreak that the case-patient was part of

Case-patient identification number

What was the result of specimen testing for diagnosis using PCR at CDC? (Do not enter PCR results if PCR was performed for speciation or subtyping).

What was the result of specimen testing using PCR at a clinical laboratory? (where goal of testing is primary detection not subtyping or speciation)

Name of PCR assay used

What was the result of specimen testing for diagnosis using PCR at the state public health laboratory? (Do not enter PCR results if PCR was performed for speciation or subtyping).

Unique identification number for person or patient

Unique identifier for laboratory result

Is all of the information for this case complete?

Was specimen or isolate forwarded to CDC for testing or confirmation?

State lab identification number

Case patient's specimen collection source

Was the isolate sent to a state public health laboratory? (Answer 'Yes' if it was sent to any state lab, even if it was sent to a lab outside of the case's state of residence)

If case-patient traveled internationally, to where did they travel?

Did the case patient travel internationally? (within 15 days of onset)

In the two weeks before onset of illness, did the case-patient travel out of their state or US?

Domestic destination or state(s) the case-patient traveled to in the two weeks before onset of illness

What treatment did the case-patient receive?

Performing laboratory type

If other non-Cyclospora organism(s) identified from stool specimen(s), indicate the organism

If the travel exposure window used by the jurisdiction is different from that stated in the travel exposure questions, specify the time interval in days here. Otherwise, leave blank.

Did the case patient travel domestically within program specific timeframe?

If the epidemiologic exposure window used by the jurisdiction is different from that stated in the exposure questions, specify the time interval in days here. Otherwise, leave blank.

Reason for travel related to current illness

For each fresh lettuce exposure reported, indicate the type of packaging of the fresh lettuce

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_FreshProduce\_FDD

PHVS\_InterviewStatus\_CDC

PHVS\_TravelDestinationType\_FDD

PHVS\_TravelMode\_CDC

PHVS\_TravelPurpose\_FDD

FDD\_Q\_77 (PHIN\_Questions\_FDD)

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_WeightUnit\_UCUM

PHVS\_WeightUnit\_UCUM

PHVS\_YesNoUnknown\_CDC

PHVS\_TemperatureUnit\_UCUM

PHVS\_CyclosporiasisSignsSymptoms\_FDD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_FreshBerries\_FDD

PHVS\_FreshHerbs\_FDD

PHVS\_LettuceType\_FDD

PHVS\_FreshProduce\_FDD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_BodySite\_CDC

PHVS\_Specimen\_CDC

PHVS\_ResultStatus\_HL7\_2x

PHVS\_LabTestName\_CDC

PHVS\_UnitsOfMeasure\_CDC

PHVS\_LabTestResultQualitative\_CDC

PHVS\_Microorganism\_CDC

PHVS\_ObservationResultStatus\_HL7\_2x

PHVS\_AbnormalFlag\_HL7\_2x

PHVS\_LabTestMethods\_CDC

PHVS\_MissingLabResult\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_MicrobiologicalStrain\_CDC

PHVS\_TrueFalse\_CDC

PHVS\_PatientLocationStatusAtSpecimenCollection

PHVS\_YesNoUnknown\_CDC

PHVS\_IsolateNotReceivedReason\_NND

PHVS\_YesNoUnknown\_CDC

N/A

P

PHVS\_YesNoUnknown\_CDC

P

N/A

P

PHVS\_TravelPurpose\_FDD



TBD



CDC Priority (New)





Label/Short Name

Childhood Primary Series?

Number of Doses if <18 years old

Boosters as Adult?

Last Dose

Clinical Description

Fever?

If Yes, Temp

Sore Throat?

Difficulty Swallowing?

Membrane?

If Yes, Tonsils?

If Yes, Soft Palate?

If Yes, Hard Palate?

If Yes, Larynx?

If Yes, Nares?

If Yes, Nasopharynx?

If Yes, Conjunctiva?

If Yes, Skin?

Change in Voice?

Shortness of Breath?

Weakness?

Fatigue?

Other?

Soft Tissue Swelling?

Neck Edema?

If Yes

If Yes, Extent

Stridor?

Wheezing?

Palatal Weakness?

Tachycardia?

EKG Abnormalities?

Complications?

Airway Obstruction?

AO Onset Date

Intubation Required?

Myocarditis?

Myocarditis Onset Date

(Poly)neuritis?

(Poly)neuritis Onset date

Other?

Describe

Diphtheria Culture

Culture Date

Culture Result

Lab Name  
Biotype  
Toxigenicity Test  
Specimen Sent to CDC

Specimen Type  
Serum Specimen for Ab Testing  
PCR Result  
Antibiotic Treatment  
Outpatient Treatment  
Date Initiated  
Antibiotic as Outpatient  
OP Therapy Duration  
Antibiotic Therapy in Hospital  
Inpatient Treatment  
Antibiotic as Inpatient  
IP Therapy Duration  
Antibiotics Before Culture  
Country of Residence  
Other Country  
US Arrival Date  
International Travel  
Country(s) Visited  
International Departure Date  
International Return Date  
Interstate Travel  
State(s) Visited  
Interstate Departure Date  
Interstate Return Date  
Exposure to Case or Carrier?  
Exposure to International Travelers?

Exposure to Immigrants?  
DAT Administered  
Final Diagnosis  
Final Diagnosis Confirmation

## Description

Did the patient receive primary a vaccination series?

If patient <18 years old, how many doses of vaccine were received?

Did the patient receive vaccine booster doses as an adult?

What is the date of patient's last dose of vaccine?

Description of patient's clinical picture

Did/does the patient have a fever?

The units of measure of the highest measured temperature in Celsius.

Did/does the patient have a sore throat?

Did/does the patient have difficulty swallowing?

Did/does the patient have a pseudomembrane?

Were/are the tonsils the site of the membrane?

Was/is the soft palate the site of the membrane?

Was/is the hard palate the site of the membrane?

Was/is the larynx the site of the membrane?

Were/are the nares the site of the membrane?

Was/is the nasopharynx the site of the membrane?

Was/is conjunctiva the site of the membrane?

Was/is the skin site of the membrane?

Did/does the patient experience shortness of breath?

Did/does the patient have voice change?

Did/does the patient have weakness?

Did/does the patient have fatigue?

Did/does the patient have any other symptoms?

Did/does the patient have soft tissue swelling?

Did/does the patient have neck edema?

If neck edema, was it bilateral, left side only, or right side only?

If neck edema, extent of the neck edema

Did/does the patient have stridor?

Did/does the patient have wheezing?

Did/does the patient have weakness?

Did/does the patient have tachycardia?

Did/does the patient have EKG abnormalities?

Did/does the patient have complications due to this illness?

Did/does the patient have airway obstruction as a complication of this illness?

Patient's onset date for airway obstruction

Was intubation of the patient required?

Did/does the patient have myocarditis as a complication of this illness?

Patient's onset date for myocarditis

Did/does the patient have (poly)neuritis as a complication of this illness?

Patient's onset date for (poly)neuritis

Did/does the patient experience any other complications due to this illness?

Description of other complications due to this illness.

Was a specimen for diphtheria culture obtained?

If yes, date culture specimen obtained

What is the result for culture specimen?

Specify laboratory performing culture

If culture result positive, specify biotype

If culture positive, what is the result of toxigenicity testing?

Was a specimen sent to the CDC Diphtheria Lab for confirmation/molecular typing?

Indicate type of specimen sent to CDC

Was a serum specimen for diphtheria antitoxin antibodies obtained?

Specify the PCR result

Was patient treated with antibiotics?

Did patient receive treatment as an outpatient?

If yes, what is the date outpatient treatment initiated?

What antibiotic did the patient receive?

What was the duration of therapy (in days)?

Was antibiotic therapy obtained in a hospital?

Did patient receive treatment as an inpatient?

What antibiotic did the patient receive?

What was the duration of therapy (in days)?

Did patient receive antibiotics in the 24 hours before culture specimen taken?

What is patient's country of residence?

If other than US, what is the country?

What is the date of patient's arrival in the US?

Did patient have history of international travel 2 weeks prior to symptom onset?

What country(s) were visited?

Date the patient left for international travel

Date the patient returned from international travel

Did patient have history of interstate travel 2 weeks prior to symptom onset?

What state(s) were visited?

Date the patient left for interstate travel

Date the patient returned from interstate travel

Was patient exposed to a known case or carrier of diphtheria?

Did the patient have a known exposure to any international travelers?

Did the patient have a known exposure to any immigrants?

Units of DAT administered

What was the final clinical diagnosis for this patient?

How was the final diagnosis confirmed?

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

Label/Short Name

Animal Contact Questions Indicator

Animal Contact Indicator

Animal Type Code(s)

Animal Type Other

Amphibian Other

Reptile Other

Mammal Other

Animal Contact Location

Acquired New Pet

Applicable Incubation Period

Associated with Daycare Indicator

Day Care Attendee

Day Care Worker

Live with Day Care Attendee

Day Care Type

Day Care Facility Name

Food Prepared at this Daycare

Diapered Infants at this Daycare

Drinking Water Exposure Indicator

Home Tap Water Source Code

Home Well Treatment Code

Home Tap Water Source Other

School/Work Tap Water Source Code

School/Work Well Treatment Code

School/Work Tap Water Source

Other

Drink Untreated Water 14 days Prior  
to Onset

Food Handler

Food Handler after Illness Onset

Food Handler Last Worked Date

Food Handler Location

Recreational Water Exposure  
Questions Indicator

Recreational Water Exposure 14  
Days Prior to Onset

Recreational Water Exposure Type  
Code(s)

Recreational Water Exposure Type  
Other

Swimming Pool Type Code(s)

Swimming Pool Type Other

Recreational Water Location Name

Related Case Indicator  
Patient Knows of Similarly Ill Persons

Health Department Investigated

Other Related Cases  
Travel Questions Indicator  
Travel Prior To Onset  
Incubation Period  
Travel Purpose Code(s)  
Travel Purpose Other  
Destination 1 Type:  
(Domestic) Destination 1:  
(International) Destination 1  
Mode of Travel: (1)  
Date Of Arrival (1)  
Date of Departure (1)  
Destination 2 Type  
(Domestic) Destination 2  
(International) Destination 2  
Mode of Travel: (2)  
Date of Arrival: (2)  
Date of Departure (2)  
Destination 3 Type:  
(Domestic) Destination 3:  
(International) Destination 3  
Mode of Travel: (3)  
Date of Arrival: (3)  
Date of Departure (3)  
Other Destination Txt  
Reporting Lab Name  
Reporting Lab CLIA Number

Local record ID (case ID)

Filler Order Number  
Ordered Test Name

Date of Specimen Collection  
Specimen Site

Specimen Number  
Specimen Source

## Specimen Details

Date Sample Received at Lab

Sample Analyzed date

Lab Report Date

Report Status

Resulted Test Name

Numeric Result

Result Units

Coded Result Value

Organism Name

Lab Result Text Value

Result Status

Interpretation Flag

Reference Range From

Reference Range To

Test Method

Lab Result Comments

Date received in state public health  
lab

Lab Test Coded Comments

Genotyping/ Subtyping

Genotyping Sent Date

Genotype/Subtype location

Genotype

Subtype

Track Isolate

Patient status at specimen collection

Isolate received in state public health  
lab

Reason isolate not received

Reason isolate not received (Other)

Date received in state public health  
lab

State public health lab isolate id  
number

Case confirmed at state public health  
lab

AgClinic

AgClinicTestType

AgeMnth

AgeYr

AgSphl

AgSphlTestType

BloodyDiarr

Diarrhea

DtAdmit2

DtDisch2

DtEntered

DtRcvd

DtRptComp

DtSpec

DtUSDepart

DtUSReturn

EforsNum

Fever

HospTrans

Immigrate

Interview

LabName

LocalID

OtherCdcTest

OtherClinicTest

OtherClinicTestType

OtherSphlTest

OtherSphlTestType

OutbrkType

PatID

PcrCdc

PcrClinic

PcrClinicTestType

PcrSphl

PersonID

ResultID

RptComp

SentCDC

SLabsID

SpeciesClinic  
SpeciesSphl  
SpecSite  
StLabRcvd

TravelDest  
TravelInt

## Description

If contact with animal, then display the following questions

Did patient come in contact with an animal?

Type of animal: (MULTISELECT)

If "Other," please specify other type of animal:

If "Other Amphibian," please specify other type of amphibian:

If "Other Reptile," please specify other type of reptile:

If "Other Mammal," please specify other type of mammal:

Name or Location of Animal Contact:

Did the patient acquire a pet prior to onset of illness?

Applicable incubation period for this illness is

If Patient associated with a day care center:

Attend a day care center?

Work at a day care center?

Live with a day care center attendee?

What type of day care facility?

What is the name of the day care facility?

Is food prepared at this facility?

Does this facility care for diapered persons?

If patient has had Drinking Water exposure, then display the following questions

What is the source of tap water at home?

If "Private Well," how was the well water treated at home?

If "Other," specify other source of tap water at home:

What is the source of tap water at school/work?

If "Private Well," how was the well water treated at school/work?

If "Other," specify other source of tap water at school/work:

Did patient drink untreated water 14 days prior to onset of illness?

If patient is a Food Handler, then display the following questions

Did patient work as a food handler after onset of illness?

What was the last date worked as a food handler after onset of illness?

Where was patient a food handler?

If patient has had recreational water exposure, then display the following

Was there recreational water exposure in the 14 days prior to illness?

What was the recreational water exposure type? (MULTISELECT)

If "Other," please specify other recreational water exposure type:

If "Swimming Pool," please specify swimming pool type: (MULTISELECT)

If "Other," please specify other swimming pool type:

Name or location of water exposure:

If related cases are associated to this case, then display the following questions

Does the patient know of any similarly ill persons?

If "Yes," did the health department collect contact information about other similarly ill persons and investigate further?

Are there other cases related to this one?

If patient has traveled, then display the following questions

Did the patient travel prior to onset of illness?

Applicable incubation period for this illness is 14 days

What was the purpose of the travel? (MULTISELECT)

If "Other," please specify other purpose of travel:

Destination 1 Type:

(Domestic) Destination 1:

(International) Destination 1

Mode of Travel: (1)

Date of Arrival: (1)

Date of Departure (1)

Destination 2 Type

(Domestic) Destination 2

(International) Destination 2

Mode of Travel: (2)

Date of Arrival: (2)

Date of Departure (2)

Destination 3 Type:

(Domestic) Destination 3:

(International) Destination 3

Mode of Travel: (3)

Date of Arrival: (3)

Date of Departure (3)

If more than 3 destinations, specify details here:

Name of Laboratory that reported test result.

CLIA (Clinical Laboratory Improvement Act) identifier for the laboratory that performed the test.

Sending system-assigned local ID of the case investigation with which the subject is associated. This field has been added to provide the mapping to the case/investigation to which this lab result is associated. This field should appear exactly as it ap

A laboratory generated number that identifies the test/order instance.

Ordered Test Name is the lab test ordered by the physician. It will always be included in an ELR, but there are many instances in which the user entering manual reports will not have access to this information.

The date the specimen was collected.

This indicates the physical location, of the subject, where the specimen originated. Examples include: Right Internal Jugular, Left Arm, Buttock, Right Eye, etc.

A laboratory generated number that identifies the specimen related to this test.

The medium from which the specimen originated. Examples include whole blood, saliva, urine, etc.

Specimen details if specimen information entered as text.

Date Sample Received at Lab (accession date).

The date and time the sample was analyzed by the laboratory.

Date result sent from Reporting Laboratory.

The status of the lab report.

The lab test that was run on the specimen.

Results expressed as numeric value/quantitative result.

The unit of measure for numeric result value.

Coded qualitative result value.

The organism name as a test result. This element is used when the result was reported as an organism.

Textual result value, used if result is neither numeric nor coded.

The Result Status is the degree of completion of the lab test.

The interpretation flag identifies a result that is not typical as well as how it's not typical. Examples: Susceptible, Resistant, Normal, Above upper panic limits, below absolute low.

The reference range from value allows the user to enter the value on one end of a expected range of results for the test. This is used mostly for quantitative results.

The reference range to value allows the user to enter the value on the other end of a valid range of results for the test. This is used mostly for quantitative results.

The technique or method used to perform the test and obtain the test results. Examples: Serum Neutralization, Titration, dipstick, test strip, anaerobic culture.

Comments having to do specifically with the lab result test. These are the comments from the NTE segment if the result was originally an Electronic Laboratory Report.

Date the isolate was received in state public health laboratory.

Explanation for missing result (e.g., clotting, quantity not sufficient, etc.)

Indicate whether the specimens were genotyped and/or subtyped

If the specimen was sent to the CDC for genotyping, date on which the specimens were sent.

Indicate where Genotype and/or subtype testing was performed

If the specimen was sent for genotype identification, indicate the genotype

If the specimen was sent for subtype identification, indicate the subtype

Track Isolate functionality indicator

Patient status at specimen collection

Isolate received in state public health lab

Reason isolate not received

Reason isolate not received (Other)

Date received in state public health lab

State public health lab isolate id number

Case confirmed at state public health lab

What was the result of specimen testing using an antigen-based test (e.g. EIA or lateral flow) at a clinical laboratory?

Name of antigen-based test used at clinical laboratory

Age of case-patient in months if patient is <1yr

Age of case-patient in years

What was the result of specimen testing using an antigen-based test (e.g. EIA or lateral flow) at a state public health laboratory?

Name of antigen-based test used at state public health laboratory

Did the case-patient have bloody diarrhea (self reported) during this illness?

Did the case-patient have diarrhea (self-reported) during this illness?

Date of hospital admission for second hospitalization for this illness

Date of hospital discharge for second hospitalization for this illness

Date case was entered into site's database

Date case-patient's specimen was received in laboratory for initial testing

Date case report form was completed

Case-patient's specimen collection date

If case-patient traveled internationally, date of departure from the U.S.

If case-patient traveled internationally, date of return to the U.S.

CDC FDOSS outbreak ID number

Did the case-patient have fever (self-reported) during this illness?

If case-patient was hospitalized, was s/he transferred to another hospital?

Did case-patient immigrate to the U.S.? (within 15 days of illness onset)

Was the case-patient interviewed by public health (i.e. state or local health department) ?

Name of submitting laboratory

Case-patient's medical record number

What was the result of specimen testing using another test at CDC?

What was the result of specimen testing using another test at a clinical laboratory?

Name of other test used at a clinical laboratory

What was the result of specimen testing using another test at a state public health laboratory?

Name of other test used at a state public health laboratory

Type of outbreak that the case-patient was part of

Case-patient identification number

What was the result of specimen testing for diagnosis using PCR at CDC? (Do not enter PCR results if PCR was performed for speciation or subtyping).

What was the result of specimen testing using PCR at a clinical laboratory? (where goal of testing is primary detection not subtyping or speciation)

Name of PCR assay used

What was the result of specimen testing for diagnosis using PCR at the state public health laboratory? (Do not enter PCR results if PCR was performed for speciation or subtyping).

Unique identification number for person or patient

Unique identifier for laboratory result

Is all of the information for this case complete?

Was specimen or isolate forwarded to CDC for testing or confirmation?

State lab identification number

What was the species result at clinical lab?

What was the species result at SPHL?

Case patient's specimen collection source

Was the isolate sent to a state public health laboratory? (Answer 'Yes' if it was sent to any state lab, even if it was sent to a lab outside of the case's state of residence)

If case-patient traveled internationally, to where did they travel?

Did the case patient travel internationally? (within 15 days of onset)

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

Yes No Indicator (HL7)

Yes No Unknown (YNU)

Animal Type (FDD)

Yes No Unknown (YNU)

Yes No Indicator (HL7)

Yes No Unknown (YNU)

Yes No Unknown (YNU)

Yes No Unknown (YNU)

Day CareType (FDD)

Yes No Unknown (YNU)

Yes No Unknown (YNU)

Yes No Indicator (HL7)

Tap Water Source (FDD)

Well Water Treatment (FDD)

Tap Water Source (FDD)

Well Water Treatment (FDD)

Yes No Unknown (YNU)

Yes No Indicator (HL7)

Yes No Unknown (YNU)

Yes No Indicator (HL7)

Yes No Unknown (YNU)

Recreational Water (FDD)

Swimming Pool Type (FDD)

Yes No Indicator (HL7)  
Yes No Unknown (YNU)

Yes No Unknown (YNU)

Other Related Cases  
Yes No Indicator (HL7)  
Yes No Unknown (YNU)

Travel Purpose

Travel Destination Type  
State  
Country  
Travel Mode

Travel Destination Type  
State  
Country  
Travel Mode

Travel Destination Type  
State  
Country  
Travel Mode

Ordered Test

Specimen

Specimen

Result Status (HL7)  
Lab Test Result Name (FDD)

Units Of Measure  
Lab Test Result Qualitative  
Microorganism (FDD)

Observation Result Status (HL7)  
Abnormal Flag (HL7)

Observation Method

Missing Lab Result Reason  
Yes No Unknown (YNU)

Yes No Indicator (HL7)  
Patient Location Status at Specimen Collection

Yes No Unknown (YNU)

Isolate Not Received Reason

Yes No Unknown (YNU)

Label/Short Name

DAYCARE  
FACNAME  
NURSHOME  
NHNAME  
SYNDRM  
SPECSYN  
SPECIES  
OTHBUG1  
STERSITE  
OTHSTER  
DATE  
NONSTER  
UNDERCOND  
COND  
OTHMALIG  
OTHORGAN  
OTHILL  
OTHOTHSPC  
Specify Internal Body Site  
Other Prior Illness 2  
Other Prior Illness 3  
Other Nonsterile Site  
INSURANCE  
INSURANCEOTH  
WEIGHTLB  
WEIGHTOZ  
WEIGHTKG  
HEIGHTFT  
HEIGHTIN  
HEIGHTCM  
WEIGHTUNK  
HEIGHTUNK  
SEROTYPE  
HIBVACC  
  
MEDINS  
OTHINS  
HIBCON  
  
CONTYPE  
SIGHIST  
PREWEEKS  
SPECHIV  
OTHSIGHIST  
ACUTESER

ACUTESERDT

CONVSR

CONVSRDT

BIRTHCTRY

Other Serotype

Was the patient < 15 years of age at the time of first positive culture?

Bacterial Infection Syndrome

Pregnancy Status at the Time of First Positive Culture

Pregnancy Outcome

Gestational Age

Birth Weight

Birth Weight Units

Previous Contact With Hib Disease

Hib Contact Type

Previous Contact With Non-b or Nontypeable H. influenzae Case

Non-b or Nontypeable Contact Type

Recurrent Disease with Same Pathogen

Previous State ID (Recurrent Case)

Case Report Form Status

Illness Onset Age

Illness Onset Age Units

Residence

Premature Infant

Epi-Linked to a Laboratory-Confirmed Case

ABCs Case

ABCs State ID

Laboratory Testing Performed

Laboratory Confirmed

Test Manufacturer

Lab Accession Number

Did the Subject Ever Receive a Vaccine Against This Disease

Date of Last Dose Prior to Illness Onset

Vaccination Doses Prior to Onset

Vaccine History Comments

Age at Vaccination

Age at Vaccination Units  
Vaccine History Information Source  
Vaccine Information Source Indicator  
  
Susceptibility Test

## Description

If <6 years of age, is the patient in daycare?

Name of the daycare facility.

Does the patient reside in a nursing home or other chronic care facility?

Name of the nursing home or chronic care facility.

Types of infection that are caused by the organism. This is a multi-select field.

Other infection that is caused by the organism.

Bacterial species that was isolated from any normally sterile site.

Other bacterial species that was isolated from any normally sterile site.

Sterile sites from which the organism was isolated. This is a multi-select field.

Other sterile site from which the organism was isolated.

Date the first positive culture was obtained. (This is considered diagnosis date.)

Nonsterile sites from which the organism was isolated. This is a multi-select field.

Did the patient have any underlying conditions?

Underlying conditions that the subject has. This is a multi-select field.

Other malignancy that the subject had as an underlying condition.

Detail of the organ transplant that the subject had as an underlying condition.

Other prior illness that the subject had as an underlying condition.

Another Bacterial Species not listed in the Other Bacterial Species drop-down list.

Internal Body Site where the organism was located.

Other prior illness that the subject had as an underlying condition.

Other prior illness that the subject had as an underlying condition.

Other nonsterile site from which the organism was isolated.

Patient's type of insurance (multi-selection).

Patient's other type of insurance.

Weight of the patient in pounds.

Weight of the patient in ounces.

Weight of the patient in kilograms.

Height of the patient in feet.

Height of the patient in inches.

Height of the patient in centimeters.

Indicator that the weight of the patient is unknown.

Indicator that the height of the patient is unknown.

Serotype of the culture.

If <15 years of age and serotype is 'b' or 'unk', did the patient receive Haemophilus Influenzae b vaccine?

Type of medical insurance the family has.

Other medical insurance type.

Is there a known previous contact with Hib disease within the preceding two months?

Type of previous contact with Hib disease within the preceding two months.

Patient's significant past medical history.

Number of weeks of a preterm birth (less than 37 weeks).

Specify immunosuppression/HIV.

Specify other prior condition.

Is acute serum available?

Date of acute serum availability.

Is convalescent serum available?

Date of convalescent serum availability.

Person's country of birth.

Another serotype not included in the serotype dropdown list.

Indicator whether the patient was less than 15 years of age at the time of first positive culture.

Types of infection caused by organism

At the time of first positive culture, was the patient pregnant or postpartum? (The postpartum period is defined as the 30 days following a delivery or miscarriage)

If pregnant or postpartum, what was the outcome of fetus?

If patient <1 month of age, indicate gestational age (in weeks)

If patient <1 month of age, indicate birth weight

Birth Weight Units

Is there a known previous contact(s) with Hib disease within the preceding two months?

Type of previous contact(s) with Hib disease within the preceding two months.

Did patient have known previous contact(s) with a non-b or nontypeable case of H. influenzae disease within the preceding 2 months?

Specify type of contact(s) with non-b or nontypeable case of H. influenzae

this case have recurrent disease with the same pathogen? (For Streptococcus pneumoniae, the specimen from the current case must have been isolated 8 or more days after any previous case due to the same pathogen. For all other pathogens, the specimen from the current case must have been isolated 30 or more days after any previous case due to the same pathogen.)

StateID of 1st occurrence for this pathogen and person.

Case Report Form Status

Illness onset age

Illness onset age units

Where was the patient a resident at time of initial culture?

Premature at birth (for children  $\leq 2$  years old)

Is this case epi-linked to a laboratory-confirmed case?

ABCs case?

ABCs State ID

Was laboratory testing done to confirm the diagnosis?

Was the case laboratory confirmed?

Test Manufacturer

Lab Accession Number (including CDC Lab ID)

Did the subject ever receive a vaccine against this disease?

Date of last vaccine dose against this disease prior to illness onset

Number of vaccine doses against this disease prior to illness onset

Vaccine History Comments

The persons age at the time the vaccine was given

The age units of the person at the time the vaccine was given

What sources were used for vaccination history?

Vaccination History Information Source Indicator

Was any susceptibility data available?

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

TBD

TBD  
TBD  
TBD

TBD  
PHVS\_YesNoUnknown\_CDC  
TBD

TBD

TBD

PHVS\_TrueFalse\_CDC  
PHVS\_TrueFalse\_CDC  
TBD  
PHVS\_YesNoUnknown\_CDC

TBD

PHVS\_YesNoUnknown\_CDC

TBD

PHVS\_YesNoUnknown\_CDC

|                             |   |
|-----------------------------|---|
| PHVS_YesNoUnknown_CDC       |   |
| PHVS_Country_ISO_3166-1     |   |
| PHVS_YesNoUnknown_CDC       |   |
| PHVS_InfectionType_RIBD     | P |
| PHVS_PregnacyStatus_RIBD    | P |
| PHVS_FetalOutcome_RIBD      | P |
| N/A                         | P |
| N/A                         | P |
| PHVS_WeightUnit_UCUM        | P |
| PHVS_YesNoUnknown_CDC       | P |
| PHVS_ContactType_RIBD       | P |
| PHVS_YesNoUnknown_CDC       | P |
| PHVS_ContactType_RIBD       | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_FormStatus_RIBD        | P |
| N/A                         | P |
| PHVS_AgeUnit_UCUM           | P |
| PHVS_ResidenceLocation_RIBD | P |
| PHVS_YesNoUnknown_CDC       | P |
| PHVS_YesNoUnknown_CDC       | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| N/A                         | P |
| N/A                         | P |

|                             |   |
|-----------------------------|---|
| PHVS_AgeUnit_UCUM           | P |
| PHVS_InformationSource_RIBD | P |
| PHVS_YesNoUnknown_CDC       | P |
| PHVS_YesNoUnknown_CDC       | P |

Label/Short Name

State Case ID

Date of completion of Report

Date of First Report to CDC

Notification Result Status

Condition Code

Case Class Status Code

MMWR Week

MMWR Year

Reporting State

Reporting County

National Reporting Jurisdiction

Reporting Source Type Code

Reporting Source ZIP Code

Date First Reported PHD

Person Reporting to CDC - Name

Person Reporting to CDC - Phone  
Number

Person Reporting to CDC - Title

Person Reporting to CDC - Affiliation

Type of leprosy

Subject Address County

Subject Address State

Age units at case investigation

Country of Birth

Time in U.S.

Date first entered U.S.

Subject's Sex

Race Category

Ethnic Group Code

Country of Usual Residence

Earliest Date Reported to County

Earliest Date Reported to State

Diagnosis Date

Case Disease Imported Code

Imported Country

Country of Exposure or Country  
Where Disease was Acquired

Note: use exposure or acquired  
consistently across variables

Date of Onset of symptoms

Date Leprosy first diagnosed

Initial diagnosis

Diagnosis\_Biopsy

Diagnosis\_SkinSmear

Date test performed

Test Result

Current antimicrobial Treatment

Date current antimicrobial  
Treatment

Disability

Armadillo exposure

History of Previous Illness

Date of Previous Illness

Number of doctors seen

Biopsy Performed

Biopsy Results

Biopsy Interpretation

Date of Previous Biopsy

Previous Residence

Relation to Known or Suspected  
Contact

Household contacts Examined

Additional Cases

Skin Smear Interpretation

Date of Skin Smear

Medication Administered  
Previous Treatment  
Previous Treatment Duration  
Date Treatment or Therapy Started  
Contacts Received Prophylaxis  
Number of Household Contacts  
Family/Household Contacts  
Previously Diagnosed  
Number of Family/Household  
Previously Diagnosed  
Relationship to Known or Suspected  
Contact

Additional Cases  
Patient Status

History of Post-exposure Prophylaxis  
Location of Initial Diagnosis  
Medication Stop Date  
Post-exposure or Treatment  
Post-Exposure Prophylaxis  
Medication  
History of Treatment for Latent or  
Active TB  
Medication Frequency  
Medication Frequency Unit

Medication Duration  
Medication Duration Units

Medication Recipient

Medication Dose  
Medication Dosage Unit

**Sequelae of Hansen's Disease**

## Description

States use this field to link NEDSS investigations back to their own state investigations.

Date the initial leprosy surveillance form was completed by a reporting source (physician or lab reported to the local/county/state health department).

Date the case was first reported to the CDC

Status of the notification.

Condition or event that constitutes the reason the notification is being sent

Status of the case/event as suspect, probable, confirmed, or not a case per CSTE/CDC/ surveillance case definitions.

MMWR Week for which case information is to be counted for MMWR publication.

MMWR Year (YYYY) for which case information is to be counted for MMWR publication.

State reporting the notification.

County reporting the notification.

National jurisdiction reporting the notification to CDC.

Type of facility or provider associated with the source of information sent to Public Health.

ZIP Code of the reporting source for this case.

Earliest date the case was reported to the public health department whether at the local, county, or state public health level.

Name of the person who is reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Phone Number of the person who is reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Job title / description of the person reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Affiliated Facility of the person reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Classify the diagnosis based on one of the ICD-9-CM diagnosis codes

County of residence of the subject

State of residence of the subject

Subject age units at time of case investigation

Country of Birth

Length of time this subject has been living in the U.S. (if born out of the U.S.

Provide the date that subject first entered U.S. in YYYYMM format (if born out of the U.S.)

Subject's current sex

Field containing one or more codes that broadly refer to the subject's race(s).

Based on the self-identity of the subject as Hispanic or Latino

Where does the person usually\* live (defined as their residence)

\*For the definition of 'usual residence' refer to CSTE position statement # 11-SI-04 titled "Revised Guidelines for Determining Residency for Disease Reporting" at <http://www.cste.org/ps2011/11-SI-04.pdf> .

Earliest date reported to county public health system

Earliest date reported to state public health system

Earliest date of diagnosis (clinical or laboratory) of condition being reported to public health system

Indication of where the disease/condition was likely acquired.

If the disease or condition was imported, indicates the country in which the disease was likely acquired.

Indicates the country in which the disease was potentially acquired.

Date of the beginning of the illness. Reported date of the onset of symptoms of the condition being reported to the public health system

Provide month and year first diagnosis was made (if applicable)

Was subject diagnosed in the U.S. or outside the U.S.

Was biopsy performed in the U.S.?

Was skin smear test performed

Provide date test was performed in YYYYMM format

Epidemiologic interpretation of the results of the tests performed for this case

Indicate all antimicrobial drugs used to treat subject

Indicate the date antimicrobial treatment started

Indicate any sensory abnormalities or deformities of the hands, feet or eyes

Did subject ever had direct contact with an armadillo?

Was the patient previously diagnosed with Hansen's disease?

Date of previous Hansen's Disease diagnosis

How many doctors has the patient seen for this problem?

Was a biopsy performed on the patient as a result of Hansen's disease?

TBD

Indicate the results of the biopsy

If biopsy was performed on the patient, indicate the date of biopsy.

List all places in the US. and all foreign countries a PATIENT resided (including military service) BEFORE leprosy was diagnosed.

TBD

Have any household contacts of the patient been examined

TBD

If skin smears were performed, please select the results.

Date of Skin Smear

What antibiotic was administered to the patient for Leprosy

Was the patient previously treated for Hansen's Disease

If the patient was previously treated, how many months was the patient treated.

Date the treatment was initiated

Have any household contacts of the patient started prophylaxis?

Total number of known or suspected household contacts.

Have any family members or household contacts been previously diagnosed with HD

List number of diagnosed previously with Hansen's Disease.

If answer yes to previous question regarding family member diagnosed, please check relationship.

If household contacts of the patient were examined, were any additional cases found

Indicate the patient's case status

Does the case patient have a history of being of post-exposure prophylaxis for Hansen's disease or tuberculosis (TB)

Indicate the location of the initial diagnosis of Hansen's Disease

What was the date that the case patient stopped taking antimicrobials

Indicates if medication received is for post-exposure or Hansen's treatment.

If answer is yes to the previous question regarding household contacts of the patient receiving prophylaxis, please specify PEP

Does the case patient have a history of being on treatment for latent or active TB?

Frequency of medication administered for this condition.

Unit of measure for the frequency of medication administered (e.g. daily, weekly, monthly).

Duration of medication treatment or post-exposure prophylaxis.

Unit of measure for the duration of medication administered (e.g. days, weeks, months).

Specify recipient of medication for Hansen's disease (e.g. household contact, case subject).

Dosage of medication received.

Unit of measure for medication received (e.g. milligram [mg], milligram/kilogram [mg/kg])

**Hansen's Disease complications leading to disabilities such as any sensory abnormalities or deformities of the hands, eyes, or feet.**

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_ResultStatus\_NETSS  
PHVS\_NotifiableEvent\_Disease\_Condition\_CDC\_NNDSS  
PHVS\_CaseClassStatus\_NND

PHVS\_State\_FIPS\_5-2  
PHVS\_County\_FIPS\_6-4  
PHVS\_NationalReportingJurisdiction\_NND  
PHVS\_ReportingSourceType\_NND

PHVS\_TypeofLeprosy\_CDC  
PHVS\_County\_FIPS\_6-4  
PHVS\_State\_FIPS\_5-2  
PHVS\_AgeUnit\_UCUM\_NETSS  
PHVS\_CountryofBirth\_CDC

PHVS\_Sex\_MFU  
PHVS\_RaceCategory\_CDC  
PHVS\_EthnicityGroup\_CDC\_Unk

PHVS\_CountryofBirth\_CDC

PHVS\_DiseaseAcquiredJurisdiction\_NETSS  
PHVS\_Country\_ISO\_3166-1

PHVS\_CountryofBirth\_CDC

PHVS\_DiagnosisBiopsy\_CDC  
PHVS\_DiagnosisSkinSmear\_Leprosy

PHVS\_LabTestInterpretation\_Leprosy  
PHVS\_MedicationTreatment\_Leprosy

PHVS\_MedicationTreatment\_Date\_Leprosy

PHVS\_HandsFeet\_CDC  
PHVS\_YesNoUnknown\_CDC

Yes No Unknown (YNU)

N/A

Yes No Unknown (YNU)

Yes No Unknown (YNU)

TBD

TBD

N/A

TBD

TBD  
Yes No Unknown (YNU)

TBD

TBD

TBD



TBD  
Yes No Unknown (YNU)  
N/A  
N/A  
Yes No Unknown (YNU)  
N/A  
Yes No Unknown (YNU)

N/A

N/A  
Yes No Unknown (YNU)

TBD  
Yes No Unknown (YNU)

PHVS\_LocationofInitialDiagnosis\_Hansen  
N/A  
TBD  
N/A

PHVS\_YesNoUnknown\_CDC  
N/A  
TBD

N/A  
TBD

TBD

N/A  
TBD

**TBD**



CDC Priority (New)

TBD  
TBD  
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3

2

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2

Label/Short Name  
Last Name  
First Name  
Middle Initial  
Occupation  
History of rodent exposure 8 weeks prior to illness onset  
If yes, type of rodent exposure  
Exposure occurred while cleaning  
Exposure occurred while working  
Exposure during recreational activity (camping, hiking)  
Other exposure? (explain below)  
Fever >101F (38.3C)  
Thrombocytopenia (<150,000)  
Elevated hematocrit  
Elevated creatinine  
Outcome of illness  
Autopsy performed  
Autopsy findings  
Did patient seek care before admission  
Date of pre-hospital treatment  
Outcome of treatment (sent home, diagnosed as flu, etc):  
Supplemental oxygen required  
Was patient on ECMO  
Was patient intubated  
CXR with unexplained bilateral interstitial infiltrates or suggestive of ARDS  
Notes on clinical course of illness  
Specimen collection date  
Type of specimen  
If specimen tested, at which laboratory  
Test results (i.e. titer, IgM, IgG)  
Name of patient's physician  
Physician's email  
Physician's phone number  
Elevated Hematocrit (>50)  
Elevated Creatinine (>1.2 mg/dL)  
Proteinuria  
Hematuria  
Exposure occurred from pet rodent  
Street address

Description

Patient's last name

Patient's first name

Patient's middle initial

Patient's occupation

Did patient have history of rodent exposure during 8 week period prior to illness onset?

If rodent exposure occurred, what was the type of exposure?

Did exposure occur while cleaning?

Did exposure occur while working?

Did exposure occur during a recreational activity?

Other types of exposure? (Explain)

Did patient have a fever  $>101^{\circ}\text{F}$  ( $38.3^{\circ}\text{C}$ )?

Did patient have thrombocytopenia ( $<150,000$ )?

Did patient have elevated hematocrit?

Did patient have elevated creatinine?

What was the outcome of the illness?

If patient died, was autopsy performed?

Describe autopsy findings

Did patient seek care before admission?

Date of pre-hospital treatment

What was the outcome of treatment (sent home, diagnosed as flu, etc)?

Did the patient require supplemental oxygen?

Was patient on extracorporeal membrane oxygenation (ECMO)?

Was the patient intubated?

Did patient have chest x-ray (CXR) with unexplained bilateral interstitial infiltrates or suggestive of acute respiratory distress s

Describe clinical course of illness

Specimen collection date

Type of specimen collected

If specimen tested, at which laboratory?

Test results (i.e. titer, IgM, IgG)

Name of patient's physician

Physician's email

Physician's phone number

Was Elevated Hematocrit  $>50$ ?

Was Elevated Creatinine  $>1.2$  mg/dL?

Was Proteinuria detected?

Was Hematuria detected?

Did exposure occur from a pet rodent?

What is the patient's street address?

Label/Short Name

Reason for Testing

Symptomatic

Date of Illness Onset

Jaundiced (Symptom)

Due Date

Previously Aware of Condition

Provider of Care for Condition

Liver Enzyme Test Type

Liver Enzyme Test Result Date

Liver Enzyme Upper Limit Normal

Liver Enzyme Test Result

Test Type

Test Result

anti-HCV signal to cut-off ratio

Is this case Epi-linked to another  
confirmed or probable case?

Contact With Confirmed or  
Suspected Case

Contact Type

Contact Type Indicator

In Day Care

Day Care Contact

Identified Day Care Case

Sexual Preference

Number of Male Sexual Partners

Number of Female Sexual Partners

IV Drug Use

Recreational Drug Use

Travel or Live Outside U.S. or Canada

Countries Traveled or Lived Outside  
U.S. or Canada

Principal reason for travel  
Household Travel Outside U.S. or  
Canada  
Household Countries Traveled to  
Outside U.S. or Canada  
Common-Source Outbreak  
Foodborne Outbreak- infected food  
handler  
Foodborne Outbreak - NOT an  
infected food handler  
Food Item of Associated Outbreak  
Waterborne Outbreak  
Unidentified Source Outbreak  
Food Handler

Diabetes  
Diabetes Diagnosis Date  
Ever Receive a Vaccine  
Total Doses of Vaccine  
Date of Last Dose  
Ever Receive Immune Globulin  
Date of Last IG Dose  
Mother's Race  
Mother's Ethnicity  
Mother Born Outside U.S.  
Mother's Birth Country  
Mother Confirmed Positive Prior To  
Delivery  
Mother Confirmed Positive After  
Delivery  
Mother Confirmed Positive Date  
Total Doses of Vaccine  
Ever Receive Immune Globulin  
Date the child received HBIG  
Vaccine Dose Number  
Vaccine Administered Date  
Contact With Confirmed or  
Suspected Case

Contact Type

Contact Type Indicator

Sexual Preference  
Number of Male Sexual Partners

Number of Female Sexual Partners

Number of Sex Partners  
Treated for STD  
Year of Recent Treatment for STD

Ever IDU

Ever Had Contact with Hepatitis  
Ever Contact Type

IV Drug Use

Recreational Drug Use

Long-Term Hemodialysis  
Hemodialysis

Contaminated Stick

Transfusion before 1992  
Transplant before 1992  
Clotting Factor before1987  
Blood Transfusion

Blood Transfusion Date

Outpatient IV Infusions and/or  
Injections

Other Blood Exposure

Ever a Medical / Dental Blood  
Worker

Medical / Dental Blood Worker

Medical / Dental Blood Worker -  
Frequency of Blood Contact

Public Safety Blood Worker

Public Safety Blood Worker -  
Frequency of Blood Contact

Tattoo

Location Tattoo Received from  
Piercing

Location Piercing Received from  
Dental Work / Oral Surgery

Surgery Other Than Oral

Tested for Hepatitis D  
Hepatitis Delta Infection  
Prior Negative Hepatitis Test

Verified Test Date

Hospitalized

Long Term Care Resident

Ever Incarcerated

Incarcerated More Than 24 hours

Diabetes

Diabetes Diagnosis Date

Type of Incarceration Facility

Incarceration Type Indicator

Incarcerated More Than 6 months

Year of Most Recent Incarceration

Length of Incarceration

Received Medication for Condition

Mother's Birth Country

Did the subject ever receive a vaccine?

Total Doses of Vaccine

Date of Last Dose

Tested for HBsAg Antibodies

HBsAg Antibodies Positive

Maternal HBeAg result, date

Maternal HBV DNA (or genotype),  
result, date

Maternal Alanine aminotransferase  
(ALT)

Maternal antiviral therapy, if any  
Maternal Coinfection with human  
immunodeficiency virus or hepatitis  
C virus

Maternal State/Territory of  
residence at time of infant's  
diagnosis

Infant Birthweight

Infant Time of birth (military time)

Infant State/Territory of birth

HCV RNA (NAAT) test results

HCV genotype test results

HCV antigen test results

hepatitis A RNA

Date of hepatitis A RNA test

Total bilirubin

Date of bilirubin test

Experienced homelessness

CSTE Case Definition

Information Source for Data

Signs and Symptoms

Signs and Symptoms Indicator

Date of Symptom Onset

Date of Jaundice Onset

Case Patient a Healthcare Worker

Patient Epidemiological Risk Factors

Patient Epidemiological Risk Factors  
Indicator

Contact Type

Men who have Sex with Men

Multiple Sex Partners

Previous STD History

Antiviral Medication

Birth Weight (unit)  
Vaccinated within 12 Hours of Birth

Treatment within 12 Hours of Birth

Seroconversion

Occupation and Industry Category

Occupation and Industry Category  
Indicator

Positive Results 6 Months Apart

Mother's Local Record ID

Mother Nucleic Acid Test

Mother Nucleic Acid Test Result

Mother Nucleic Acid Test Viral Load

Mother HBeAg Test

Mother HBeAg Test Result

Infant HBsAg Test

Infant HBsAg Test Result

Infant HBsAg Positive Date

Infant HBeAg Test

Infant HBeAg Test Result

Infant HBeAg Positive Date

Infant HBV DNA Test

Infant HBV DNA Test Result

Infant HBV DNA Positive Date

Infant anti-HCV Test

Infant anti-HCV Test Result

Infant anti-HCV Positive Date

Infant Nucleic Acid Test

Infant Nucleic Acid Test Result

Infant Nucleic Acid Positive Date

Infant HCV Antigen Test

Infant HCV Antigen Test Result

Infant HCV Antigen Positive Date

Tissue or organ transplant

Non-injection Drug Use

Specimen From Mother or Infant  
Transplant Date

Subject of Lab Test Performed

Previously Infected Individual

Previous State Case Number

Other Reported Case(s)

Type of Outbreak

Other Reported Cases(s) Prior Years

Test Conversion

Birth Sex

Sexual Orientation

Gender Identity

Alanine Aminotransferase (ALT)  
Result

Vaccine Series Completed  
Donor Screening

Travel Outside USA Prior to Illness  
Onset (within Program Specific  
Timeframe)

Specify Different Travel Exposure  
Window

International Destination(s) of  
Recent Travel  
Date of Arrival to Travel Destination

Date of Departure from Travel  
Destination  
Laboratory Test Ordering Facility  
Type

## Description

Listing of the reason(s) the subject was tested for hepatitis.

Was the subject symptomatic for hepatitis?

Date of the beginning of the illness. Reported date of the onset of symptoms of the condition being reported to the public health system

Was the subject jaundiced?

Subject's pregnancy due date

Was the subject aware they had Hepatitis prior to lab testing?

Does the subject have a provider of care for Hepatitis? This is any healthcare provider that monitors or treats the patient for viral hepatitis.

Liver Enzyme Test Type

Liver Enzyme Test Result Date

Liver Enzyme Upper Limit Normal

Liver Enzyme Test Result

Epidemiologic interpretation of the type of test(s) performed for this case.

Epidemiologic interpretation of the results of the test(s) performed for this case.

Used to specify the anti-HCV signal to cut-off ratio if antibody to Hepatitis C virus was the test performed.

Specify if this case is Epidemiologically-linked to another confirmed or probable case of hepatitis?

During the 2-6 weeks prior to the onset of symptoms, was the subject a contact of a person with confirmed or suspected hepatitis virus infection?

During the 2-6 weeks prior to the onset of symptoms, type of contact the subject had with a person with confirmed or suspected hepatitis virus infection

During the 2-6 weeks prior to the onset of symptoms, answer (Yes, No, Unknown) for each type of contact the subject had with a person with confirmed or suspected hepatitis virus infection

During the 2-6 weeks prior to the onset of symptoms, was the subject a child or employee in daycare center, nursery, or preschool?

During the 2-6 weeks prior to the onset of symptoms, was the subject a household contact of a child or employee in a daycare center, nursery, or preschool?

Was there an identified hepatitis case in the childcare facility?

What is/was the subject's sexual preference?

During the 2-6 weeks prior to the onset of symptoms, number of male sex partners the person had.

During the 2-6 weeks prior to the onset of symptoms, number of female sex partners the person had.

During the 2-6 weeks prior to the onset of symptoms, did the subject inject drugs not prescribed by a doctor?

During the 2-6 weeks prior to the onset of symptoms, did the subject use street drugs but not inject?

During the 2-6 weeks prior to the onset of symptoms, did the subject travel or live outside the U.S.A. or Canada?

The country(s) to which the subject traveled or lived (outside the U.S.A. or Canada) prior to symptom onset.

What was the principal reason for travel?

During the 3 months prior to the onset of symptoms, did anyone in the subject's household travel outside the U.S.A. or Canada?

The country(s) to which anyone in the subject's household traveled (outside the U.S.A. or Canada) prior to symptom onset.

Is the subject suspected as being part of a common-source outbreak?

Subject is associated with a foodborne outbreak that is associated with an infected food handler.

Subject is associated with a foodborne outbreak that is not associated with an infected food handler.

Food item with which the foodborne outbreak is associated.

Subject is associated with a waterborne outbreak .

Subject is associated with an outbreak that does not have an identified source.

During the 2 weeks prior to the onset of symptoms or while ill, was the subject employed as a food handler?

Does subject have diabetes?

If subject has diabetes, date of diabetes diagnosis.

Did the subject ever receive the hepatitis A vaccine?

Number of doses of hepatitis A vaccine the subject received.

Year the subject received the last dose of hepatitis A vaccine.

Has the subject ever received immune globulin?

Date the subject received the last dose of immune globulin.

Race of the subject's mother.

Ethnicity of the patient's mother.

Was mother born outside of the United States of America?

What is the birth country of the mother?

Was the mother confirmed HBsAg positive prior to or at time of delivery?

Was the mother confirmed HBsAg positive after delivery?

Date of mother's earliest HBsAg positive test result.

Number of doses of hepatitis vaccine the child received.

Has the child ever received immune globulin?

Date the child received the last dose of immune globulin.

The vaccine dose number in series of vaccination for hepatitis.

The date that the vaccine was administered.

For Acute Hepatitis B, in the 6 weeks to 6 months prior to onset of symptoms, was the patient a contact of a person with confirmed or suspected hepatitis B virus infection?

For Acute Hepatitis C, in the 2 weeks to 6 months prior to onset of symptoms, was the patient a contact of a person with confirmed or suspected hepatitis C virus infection?

For Acute Hepatitis B, in the 6 weeks to 6 months prior to onset of symptoms, type of contact with a person with confirmed or suspected hepatitis B virus infection?

For Acute Hepatitis C, in the 2 weeks to 6 months prior to onset of symptoms, type of contact with a person with confirmed or suspected hepatitis C virus infection?

For Acute Hepatitis B, in the 6 weeks to 6 months prior to onset of symptoms, answer (Yes, No, Unknown) for each type of contact the subject had with a person with confirmed or suspected hepatitis B virus infection.

For Acute Hepatitis C, in the 2 weeks to 6 months prior to onset of symptoms, answer (Yes, No, Unknown) for each type of contact the subject had with a person with confirmed or suspected hepatitis B virus infection.

What is/was the subject's sexual preference?

Prior to the onset of symptoms, number of male sex partners the person had.

For Acute Hep B, the time period prior to onset of symptoms is 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 6 months.

Prior to the onset of symptoms, number of female sex partners the person had.

For Acute Hep B, the time period prior to onset of symptoms is 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 6 months.

How many sex partners (approximately) has subject ever had?

Was the subject ever treated for a sexually transmitted disease?

Year the patient received the most recent treatment for a sexually transmitted disease.

Has the patient ever injected drugs not prescribed by a doctor, even if only once or a few times?

Was the patient ever a contact of a person who had hepatitis?

If the patient was ever a contact of a person who had hepatitis, what was the type of contact?

Prior to the onset of symptoms, did the patient inject drugs not prescribed by a doctor?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Prior to the onset of symptoms, did the patient use street drugs but not inject?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Was the patient ever on long-term hemodialysis?

Prior to the onset of symptoms, did the patient undergo hemodialysis?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Prior to the onset of symptoms, did the patient have an accidental stick or puncture with a needle or other object contaminated with blood?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Did the patient receive a blood transfusion prior to 1992?

Did the patient receive an organ transplant prior to 1992?

Did the patient receive clotting factor concentrates prior to 1987?

Prior to the onset of symptoms, did the patient receive blood or blood products (transfusion)?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Date the subject began receiving blood or blood products (transfusion) prior to symptom onset.

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Prior to the onset of symptoms, did the patient receive any IV infusions and/or injections in an outpatient setting?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Prior to the onset of symptoms, did the patient have other exposure to someone else's blood?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Was the patient ever employed in a medical or dental field involving direct contact with human blood?

Prior to the onset of symptoms, was the patient employed in a medical or dental field involving direct contact with human blood?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Subject's frequency of blood contact as an employee in a medical or dental field involving direct contact with human blood.

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Prior to the onset of symptoms, was the subject employed as a public safety worker (fire fighter, law enforcement, or correctional officer) having direct contact with human blood?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Subject's frequency of blood contact as a public safety worker (fire fighter, law enforcement, or correctional officer) having direct contact with human blood.

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Prior to the onset of symptoms, did the patient receive a tattoo?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Location(s) where the patient received a tattoo

Prior to the onset of symptoms, did the patient receive a piercing (other than ear)?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Location(s) where the patient received a piercing (other than ear)

Prior to the onset of symptoms, did the patient have dental work or oral surgery?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Prior to the onset of symptoms, did the patient have surgery (other than oral surgery)?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Was the patient tested for Hepatitis D

Did patient have a co-infection with Hepatitis D?

Did the patient have a negative hepatitis-related test in the previous 6 months?

For Hep B: Did patient have a negative HBsAg test in the previous 6 months?

For Hep C: Did patient have a negative HCV antibody test in the previous 6 months?

If patient had a negative hepatitis-related test test in the previous 6 months, please enter the test date.

Prior to the onset of symptoms, was the patient hospitalized?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Prior to the onset of symptoms, was the patient a resident of a long-term care facility?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Was the patient ever incarcerated?

Prior to the onset of symptoms, was the patient incarcerated for longer than 24 hours?

For Acute Hep B, the time period prior to onset of symptoms is 6 weeks - 6 months.

For Acute Hep C, the time period prior to onset of symptoms is 2 weeks - 6 months.

Does subject have diabetes?

If subject has diabetes, date of diabetes diagnosis.

Type of facility where the patient was incarcerated for longer than 24 hours before symptom onset.

Was the patient ever incarcerated for longer than six months during his or her lifetime?

Year the patient was most recently incarcerated for longer than six months.

Length of time the patient was most recently incarcerated for longer than six months.

Has the subject ever received medication for the type of Hepatitis being reported?

What is the birth country of the mother?

Did the subject ever receive a hepatitis B vaccine?

Number of doses of hepatitis B vaccine the patient received.

Year the patient received the last dose of hepatitis B vaccine.

Was the patient tested for antibody to HBsAg (anti-HBs) within one to two months after the last dose?

Was the serum anti-HBs  $\geq 10$  ml U/ml? (Answer 'Yes' if lab result reported as positive or reactive.)

Maternal HBeAg result, date

Maternal HBV DNA (or genotype), result, date

Maternal Alanine aminotransferase (ALT)

Maternal antiviral therapy, if any

Maternal Coinfection with human immunodeficiency virus or hepatitis C virus

Maternal State/Territory of residence at time of infant's diagnosis

Infant Birthweight

Infant Time of birth (military time)

Infant State/Territory of birth

HCV RNA (NAAT) test results and timing of test performance

HCV genotype test results and timing of test performance

HCV antigen test results and timing of test performance

Nucleic acid amplification test (NAAT; such as PCR or genotyping) for hepatitis A virus RNA

Date of hepatitis A RNA test

Total bilirubin levels

Date of bilirubin test

In the 2-6 weeks prior to symptom onset, was the patient homeless?

Did the patient meet the CSTE case definition(s) for any of the following in a previous reporting year? (*select all that apply*)

Source of Laboratory Test: (*select all that apply*)

Signs and symptoms associated with the illness being reported

Response for each of the signs and symptoms.

The date and time, if available, of the symptom onset (clinical manifestation)

What was the date of jaundice onset?

Was the patient employed as a healthcare worker during the TWO WEEKS prior to onset of symptoms to ONE WEEK after onset of JAUNDICE? (If no jaundice, use two weeks after onset of symptoms)

Exposed risk factors for the patient - Please provide a response for all risk factors in the value set with an associated indicator.

In the 15 to 50 days before symptom onset date for hepatitis A.

In the 60 to 150 days (2 to 5 months) before symptom onset date for hepatitis B.

In the 14 to 182 days (2 weeks to 6 months) before symptom onset date for hepatitis C.

Provide a response for each value in the patient epidemiological risk factors value set.

If the patient was a contact of a person with confirmed or suspected hepatitis virus infection, was the contact: (*select all that apply*)

Was the patient a man who reported sexual activity with men?

Did the patient report multiple sex partners?

Was the patient diagnosed with a sexually transmitted disease?

Did the gestational parent receive hepatitis B antiviral therapy during the third trimester of pregnancy?

The patient's birth weight units

Did the patient receive the hepatitis B vaccine within 12 hours of birth?

Did the patient receive the hepatitis B immune globulin within 12 hours of birth?

If hepatitis B case, did the patient meet the acute hepatitis B seroconversion criteria? *(i.e., documented negative HBsAg laboratory test result within 6 months prior to a positive test [HBsAg, HBeAg, or nucleic acid test for HBV DNA (including qualitative, quantitative, and genotype testing)] in someone without a prior diagnosis of HBV infection)*

If hepatitis C case, did the patient meet the acute hepatitis C seroconversion criteria? *(e.g., documented negative anti-HCV followed within 12 months by a positive anti-HCV test; or documented negative anti-HCV or negative HCV detection test [in someone without a prior diagnosis of HCV infection] followed within 12 months by a positive HCV detection test; or, in the case of presumed reinfection, at least two sequential negative HCV detection tests [in someone with a prior diagnosis of HCV infection] followed by a positive HCV detection test).*

Was the patient employed as a food handler or a healthcare worker during the TWO WEEKS prior to onset of symptoms to ONE WEEK after the onset of JAUNDICE? (If no jaundice, use two weeks after onset of symptoms)

Please indicate for each occupation:

Did the patient have two positive results at least 6 months apart from any of the following tests: (1) HBsAg; (2) nucleic acid test for HBV DNA (including qualitative, quantitative, and genotype testing); (3) HBeAg? *(Any combination of these positive tests performed at least 6 months apart is acceptable)*

Provide the local record ID used for reporting mother's case of hepatitis (DE Identifier "N/A: OBR-3"). This will be used for linking the reported perinatal case to the mother's reported hepatitis case.

For hepatitis B, perinatal, did the gestational parent receive nucleic acid testing for HBV DNA during pregnancy?

For hepatitis C, perinatal, did the gestational parent receive nucleic acid testing for HCV RNA (including qualitative or quantitative PCR, or genotype testing) during pregnancy?

For hepatitis B, perinatal, if the gestational parent received nucleic acid testing for HBV DNA during pregnancy, then indicate the result.

For hepatitis C, perinatal, if the gestational parent received nucleic acid testing for HCV RNA (including qualitative or quantitative PCR, or genotype testing) during pregnancy, then indicate the result.

If the gestational parent received nucleic acid testing for HBV DNA during pregnancy, then indicate the viral load:

Did the gestational parent receive HBeAg testing during pregnancy?

If the gestational parent received HBeAg testing during pregnancy, indicate the result.

Did the patient receive an HBsAg test between age 1–24 months (only if  $\geq 4$  weeks after the last dose of hepatitis B vaccine)?

If the patient received an HBsAg test between age 1–24 months (only if  $\geq 4$  weeks after the last dose of hepatitis B vaccine), indicate the result.

If positive, then indicate the date of the first positive HBsAg test between age 1–24 months.

Did the patient receive an HBeAg test between age 9–24 months?

If the patient received an HBeAg test between age 9–24 months, indicate the result.

If positive, then indicate the date of the first positive HBeAg test between age 9–24 months.

Did the patient receive an HBV DNA test between age 9–24 months?

If the patient received an HBV DNA test between age 9–24 months, indicate the result.

If detected/positive, then indicate the date of the first positive HBV DNA test between age 9–24 months.

Did the patient receive an anti-HCV test between age 18–36 months?

If the patient received an anti-HCV test between age 18–36 months, indicate the result.

If positive, then indicate the date of the first positive anti-HCV test between age 18–36 months.

Did the patient receive nucleic acid testing for HCV RNA (including qualitative or quantitative PCR, or genotype testing) between age 2-36 months?

If the patient received nucleic acid testing for HCV RNA (including qualitative or quantitative PCR, or genotype testing) between age 2-36 months, indicate the result.

If detected/positive, then indicate the date of the first positive nucleic acid test for HCV RNA between age 2-36 months.

Did the patient receive HCV antigen test between age 2-36 months?

If the patient received HCV antigen test between age 2-36 months, indicate the result.

If positive, then indicate the date of the first positive HCV antigen test between age 2-36 months.

Did the patient receive tissue or organ transplant(s)?

Did the patient use non-injection drugs not prescribed by a doctor or engage in nonmedical use of prescription drugs?

V1.0 only: During the 2-6 weeks prior to the onset of symptoms, did the subject inject drugs not prescribed by a doctor?

Is the specimen from the gestational parent or the infant?

Date(s) of organ transplant(s).

Indication to specify whether the Lab Test Performed was for the mother or infant.

Did the subject meet the case definition for a previous case investigation of this disease or condition?

If the subject previously met the case definition for the disease or illness, what was the previously submitted sending system-assigned local ID (case ID) of the case investigation with which the subject is associated?

Select all of the newly reported case(s) of the hepatitides confirmed within the current reporting year other than the primary condition reported for this case notification.

If the person is suspected of being part of an outbreak, please select the source of the outbreak.

Select the relevant conditions for which the patient met the CSTE case definition(s) in any previous reporting year. Select all that apply.

Did the patient meet the program criteria for test conversion for the condition of interest?

Sex assigned at birth

A person's identification of their emotional, romantic, sexual, or affectional attraction to another person

A person's internal sense of being a man, woman, both, or neither

What was the patient's ALT level (IU/L)?

Note: The result of the ALT test performed on the same specimen as the positive hepatitis A, B or C lab result(s) or associated with the positive hepatitis A, B or C lab result(s).

CDC's preference is for the qualitative result to be submitted when available rather than the quantitative option.

Was the vaccine series completed?

Patient was determined to have viral hepatitis during screening for blood, organ, or tissue donation. Please indicate the donation type.

Did the patient travel or live internationally in the 15 to 50 days before symptom onset date?

Note: If the symptom onset date is unknown, then the date that the patient first tested positive for hepatitis A virus (HAV) can be used as a proxy for symptom onset date.

If the travel exposure window used by the jurisdiction is different from that stated in the travel exposure questions, specify the time interval in days here. Otherwise, leave blank.

International destination or countries the patient traveled to or lived in, in the 15 to 50 days before symptom onset date

Date of arrival to travel destination

Date of departure from travel destination

Type of facility where the hepatitis laboratory screening, diagnostic, or monitoring test was ordered

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_ReasonForTest\_Hepatitis

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_LabTestTypeEnzymes\_Hepatitis

PHVS\_LabTestType\_Hepatitis

PHVS\_PosNegUnk\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_ContactType\_HepatitisA

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_SexualPreference\_NETSS

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_Country\_ISO\_3166-1

PHVS\_TravelReason\_HepatitisA  
PHVS\_YesNoUnknown\_CDC

PHVS\_Country\_ISO\_3166-1

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_RaceCategory\_CDC  
PHVS\_EthnicityGroup\_CDC\_Unk  
PHVS\_YesNoUnknown\_CDC  
PHVS\_Country\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_ContactType\_HepatitisBandC

PHVS\_YesNoUnknown\_CDC

PHVS\_SexualPreference\_NETSS

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_ContactType\_HepatitisBandC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

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PHVS\_YesNoUnknown\_CDC  
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PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_BloodContactFrequency\_Hepatitis

PHVS\_YesNoUnknown\_CDC

PHVS\_BloodContactFrequency\_Hepatitis

PHVS\_YesNoUnknown\_CDC

PHVS\_TattooObtainedFrom\_Hepatitis  
PHVS\_YesNoUnknown\_CDC

PHVS\_TattooObtainedFrom\_Hepatitis  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
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PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_IncarcerationType\_Hepatitis

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_Country\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

|                                                                                                                                                   |                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| PHVS_LabTestResultQualitative_CDC                                                                                                                 | P                                                                                    |
| N/A                                                                                                                                               | P                                                                                    |
| N/A                                                                                                                                               | P                                                                                    |
| N/A                                                                                                                                               | P                                                                                    |
| <a href="#">PHVS_YesNoUnknown_CDC</a>                                                                                                             | P                                                                                    |
| TBD                                                                                                                                               |  |
| TBD                                                                                                                                               |                                                                                      |
| TBD                                                                                                                                               |                                                                                      |
| <a href="#">Yes No Unknown (YNU)https://phinvads.cdc.gov/vads/ViewValueSet.a</a>                                                                  |                                                                                      |
| N/A                                                                                                                                               |                                                                                      |
| N/A                                                                                                                                               |                                                                                      |
| Yes No Unknown (YNU)                                                                                                                              |                                                                                      |
| <a href="https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888">https://phinvads.cdc.gov/vads/ViewValueSet.action?</a> |                                                                                      |
| <a href="https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888">oid=2.16.840.1.114222.4.11.888</a>                     |                                                                                      |
| TBD                                                                                                                                               |                                                                                      |
| <a href="#">Yes No Unknown (YNU)https://phinvads.cdc.gov/vads/ViewValueSet.a</a>                                                                  |                                                                                      |
| TBD                                                                                                                                               |                                                                                      |

[Yes No Unknown \(YNU\)https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

[Yes No Unknown \(YNU\)https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

[Yes No Unknown \(YNU\)https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

Yes No Unknown (YNU)  
<https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888>

TBD

Yes No Unknown (YNU)  
<https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888>

Yes No Unknown (YNU)  
<https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888>

Yes No Unknown (YNU)  
<https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888>

TBD

Yes No Unknown (YNU)  
<https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888>

Yes No Unknown (YNU)  
<https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888>

N/A

Yes No Unknown (YNU)  
[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

TBD

TBD

Yes No Unknown (YNU)  
[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

TBD

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[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

TBD

N/A

Yes No Unknown (YNU)  
[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

TBD

N/A

Yes No Unknown (YNU)  
[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

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N/A

Yes No Unknown (YNU)  
[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

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Yes No Unknown (YNU)  
[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
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TBD

N/A

Yes No Unknown (YNU)  
[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

TBD

N/A

Yes No Unknown (YNU)  
[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

Yes No Unknown (YNU)  
[https://phinvads.cdc.gov/vads/ViewValueSet.action?  
oid=2.16.840.1.114222.4.11.888](https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888)

PHVS\_SpecimenFromMotherOrInfant\_CRS  
NA

PHVS\_MotherInfantIndicator\_NND

Yes No Unknown (YNU)

N/A

PHVS\_NotifiableConditions\_Hepatitis

PHVS\_CSOutbreak\_HepatitisB (Per condition)

TBD

PHVS\_YesNoUnknown\_CDC

TBD (to align with USCDI standards)

TBD (to align with USCDI standards)

TBD (to align with USCDI standards)

PHVS\_AlanineATResult\_Hepatitis

PHVS\_YesNoUnknown\_CDC  
PHVS\_DonorScreening\_Hepatitis

PHVS\_YesNoUnknown\_CDC

N/A (text field)

PHVS\_Country\_ISO\_3166-1

N/A (Date)

N/A (Date)

PHVS\_SourceofLaboratoryTest \_Hepatitis



CDC Priority  
(New)

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Label/Short Name

CASEID

FIRST\_IDENT

DATE\_AS

OTHR\_IDENT\_DESC

HDD

HDD\_DATE

DATEHUS

OUTBREAK

DIARRHEA

DONSET

STOOLBLOOD

DTREATED

A1ANTI

CONTACT

OTHREA

A3ANTI

A4REAS

GASTRO

UTI

RTI

ACUTE

DACUTE

PREG

KIDN

IMMCOMP

MALIG

TRANSPL

HIV

STER

IMMOTHER

CRE

BUN

WBC

HGB

HCT

PLT

RCFRAG

BURINE

PURINE

RBCURINE

STOOLSPEC

TESTSHIGA

N11BRESULT

STSPEC

STECPOS

CULTO157

DATEO157

O157ISOL

DATEO157POS

HANT

HANT\_OTHER

STOOL\_CDC\_PHL

SPEC\_DATEPHLSTEC

STEC\_ISOL

O

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IMS

IMS\_SERO

OTHERPATH

PATH1

PATH1D

PATH2  
PATH2D  
PATHNOS  
DESPATH  
SPECPATH

DATEPATH

STATELAB  
F9MENUREF

CDC  
CDC\_ID  
REFLAB  
SPECIFY\_REFLAB

FNCATCH  
PERSONID  
ANTIO157

SLABID\_SERUM  
OTHERSLABSID\_SERUM  
LPS\_TYPE1  
IGG\_1  
IGG\_INTERP  
IGM\_1  
IGM1\_INTERP  
LPS\_TYPE2  
IGG\_2  
IGG\_INTERP2  
IGM\_2  
IGM1\_INTERP2  
LPS\_TYPE3  
IGG\_3  
IGG\_INTERP3  
IGM\_3  
IGM1\_INTERP3  
ADMISR  
DISCHR  
PNE  
DPNE  
SZR  
DSZR  
PAR

DPAR  
BLN

DBLN  
NER

DNER  
DESCR1  
PDIAL  
HDIAL  
PRBC

PLTT  
FFPL  
PHRES  
SURG

SURGDES  
CONDDC  
DEAD  
REQDIAL  
NEURODEF

## Description

Case patient's ID

How was patient's illness first identified by public health (state or local health department or EIP)?

Date case entered into data system (Complete if FIRST\_IDENT=1)

Describe other way patient's illness first identified by public health (Complete if FIRST\_IDENT=4).

Was this case captured through Hospital Discharge Data?

Date case entered into data system (Complete if HDD=1)

Date of HUS diagnosis

Is this case outbreak-related?

Did patient have diarrhea during the 3 weeks before HUS diagnosis?

Date of diarrhea (Complete if DIARRHEA=1)

Did stools contain visible blood at any time? (Complete if DIARRHEA=1)

Was diarrhea treated with antimicrobial medications/ (Complete if DIARRHEA=1)

Type of antimicrobial (Complete if DTREATED=1)

Did the patient have contact with another person with diarrhea or HUS during the 3 weeks before HUS diagnosis (include daycare, household, etc)? (Complete if DIARRHEA=2)

Was patient treated with an antimicrobial medication for any other reason than diarrhea during the 3 weeks before HUS diagnosis?

Type of antimicrobial (Complete if OTHREA=1)

Reason for antimicrobial (Complete if OTHREA=1)

Was other gastrointestinal illness present during 3 weeks before HUS diagnosis?

Did patient have a urinary tract infection during 3 weeks before HUS diagnosis?

Did patient have a respiratory tract infection during 3 weeks before HUS diagnosis?

Did patient have other acute illness during 3 weeks before HUS diagnosis?

Describe other acute illness (Complete if ACUTE=1)

Was patient pregnant during 3 weeks before HUS diagnosis?

Did patient have kidney disease during 3 weeks before HUS diagnosis?

Did patient have an immunocompromising condition or was the patient taking medication during 3 weeks before HUS diagnosis?

Did patient have a malignancy during 3 weeks before HUS diagnosis? (Complete if IMMCOMP=1)

Did patient have transplanted organ or bone marrow during 3 weeks before HUS diagnosis? (Complete if IMMCOMP=1)

Did patient have HIV infection during 3 weeks before HUS diagnosis? (Complete if IMMCOMP=1)

Was patient using steroids (parenteral or oral) during 3 weeks before HUS diagnosis? (Complete if IMMCOMP=1)

Describe other immunocompromising condition during 3 weeks before HUS diagnosis? (Complete if IMMCOMP=1)

Laboratory values within 7 days before and 3 days after HUS diagnosis: Highest serum creatinine (expressed as mg/dL)

Laboratory values within 7 days before and 3 days after HUS diagnosis: Highest serum BUN (expressed as mg/dL)

Laboratory values within 7 days before and 3 days after HUS diagnosis: Highest serum WBC (expressed as K/mm<sup>3</sup>)

Laboratory values within 7 days before and 3 days after HUS diagnosis: Lowest hemoglobin (expressed as g/dL)

Laboratory values within 7 days before and 3 days after HUS diagnosis: Lowest hematocrit (expressed as %)

Laboratory values within 7 days before and 3 days after HUS diagnosis: Lowest platelet count (expressed as K/mm<sup>3</sup>)

Were there microangiopathic changes (i.e., schistocytes, helmet cells or red cell fragments) at any time within 7 days before HUS diagnosis to hospital discharge (if patient was not hospitalized or discharged within 3 days of HUS diagnosis, then outpatient lab results from 7 days before to 3 days after diagnosis should be used, if available)

Other laboratory findings within 7 days before and 3 days after HUS diagnosis: Blood (or heme) in urine

Other laboratory findings within 7 days before and 3 days after HUS diagnosis: Protein in urine

Other laboratory findings within 7 days before and 3 days after HUS diagnosis: RBC in urine by microscopy

Was a stool specimen obtained from this patient?

Was stool tested for Shiga toxin at any clinical laboratory?

Result of Shiga toxin testing (Complete if TESTSHIGA=1)

Collection date of first specimen tested (Complete if TESTSHIGA=1)

Collection date of first positive specimen (Complete if TESTSHIGA=1)

Was stool cultured for E. coli O157 (on selective or differential media e.g. SMAC, CHROMagar O157, CTSMAC) at any CLINICAL laboratory?

Date stool cultured for E. coli O157 (Complete if CULTO157=1)

Was E.coli O157 isolated? (Complete if CULTO157=1)

Collection date 1st positive specimen culture for O157 (Complete if O157POS=1)

Result of H antigen testing (Complete if O157ISOL=1)

Other H antigen (Complete if HANT=5)

Was a stool sample, or any type of specimen or isolate originating from stool sent to a public health laboratory (state or CDC)?

Date of specimen collection (Complete if STOOL\_CDC\_PHL=1)

Was E.coli or non-O157 STEC identified? (Complete if STOOL\_CDC\_PHL=1)

What was the O antigen for strain 1? (Complete if STEC\_ISOL=1)

What was the H antigen for strain 1? (Complete if STEC\_ISOL=1)

What was the O antigen for strain 2? (Complete if STEC\_ISOL=1)

What was the H antigen for strain 2? (Complete if STEC\_ISOL=1)

Was immunomagnetic separation (IMS) used to identify common STEC serogroups?

What serogroup(s) did the IMS procedure target? (Complete if IMS=1)

Was another pathogen isolated from stool (at PHL or clinical lab)?

Name pathogen isolated from stool (Complete if OTHERPATH=1)

Date other pathogen isolated from stool

Name of second pathogen isolated from stool (Complete if OTHERPATH=1)

Date second other pathogen isolated from stool

Was pathogen isolated from source other than stool (at PHL or clinical lab)?

Name pathogen isolated from source other than stool (Complete if PATHNOS=1)

Specimen source of pathogen isolated from source other than stool (Complete if PATHNOS=1)

First date of isolation of pathogen from source other than stool (Complete if PATHNOS=1)

If O157 or other STEC was isolated, was the isolate sent to state laboratory?

If isolate sent to state laboratory, what was the state laboratory ID (Complete if STATELAB=1)

If O157 or other STEC was isolated, was the isolate sent to CDC?

If isolate sent to CDC, what was the CDC laboratory ID (Complete if CDC=1)

If O157 or other STEC was isolated, was the isolate sent to another reference lab?

If isolate sent to reference lab, what was the name of the reference lab? (Complete if REFLAB=1)

Is the patient a resident of the FoodNet catchment area?

What is the FoodNet PERSONID? (Complete if FNCATCH=1)

Has patient serum or plasma been sent to CDC for testing for antibodies to O157 or other STEC?

What is the state laboratory ID or the serum? (Complete if ANTIO157=1)

Other laboratory ID numbers for serum sent to CDC (Complete if ANTIO157=1)

LPS type

IgG titer

Interpretation of IgG titer

IgM titer

Interpretation of IgM titer

Second LPS type

Second IgG titer

Interpretation of second IgG titer

Second IgM titer

Interpretation of second IgM titer

Third LPS type

Third IgG titer

Interpretation of third IgG titer

Third IgM titer

Interpretation of third IgM titer

Date of first hospital admission

Date of last hospital discharge

Did pneumonia occur as a complication during this hospital admission?

Date of onset of pneumonia (Complete if PNE=1)

Did seizure occur as a complication during this hospital admission?

Date of onset of seizure (Complete if SZR=1)

Did paralysis or hemiparesis occur as a complication during this hospital admission?

Date of onset of paralysis or hemiparesis (Complete if PAR=1)

Did blindness occur as a complication during this hospital admission?

Date of onset of blindness (Complete if BLN=1)

Did other major neurologic sequelae occur as a complication during this hospital admission?

Date of other major neurologic sequelae (Complete if NER=1)

Describe other major neurologic sequelae (Complete if NER=1)

Was peritoneal dialysis performed during hospital stay?

Was hemodialysis performed during hospital stay?

Was packed RBC or whole blood used in dialysis? (Complete if PDIAL=1 or HDIAL=1)

Were platelets used in dialysis? (Complete if PDIAL=1 or HDIAL=1)

Was fresh frozen plasma used in dialysis? (Complete if PDIAL=1 or HDIAL=1)

Was plasmapheresis performed during hospital stay?

Was laparotomy or other abdominal surgery performed during hospital stay? Do not include insertion of dialysis catheter.

Describe other abdominal surgery

Patient's condition at hospital discharge

Date of death (Complete if CONDDC=1)

Was patient discharged requiring dialysis? (Complete if CONDDC=2)

Was patient discharged with neurologic deficits? (Complete if CONDDC=2)

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

Label/Short Name

City

State

Country

Occupation

Gender

Age

Race

Ethnicity

Animal Exposure

Animal Species

Animal State

Animal Country

Type of Exposure

Vaccination status

Travel

Travel State

Travel Country

Travel DateStart

Travel DateEnd

Onset

Hospitalized

Death

Variant

## Description

Patients City of Residence

Patients State of Residence

Patients Country of Residence

Patients Occupation

Patients Gender

Patients Age

Patients Race

Patients Ethnicity

Did patient have a history of an animal exposure

What type of animal was involved in the Exposure

What state did the animal exposure occur in

What country did the animal exposure occur in

What type of exposure occurred

Was the patient vaccinated for rabies prior to onset of symptoms

Did the patient have a recent (prior 12 months) history of travel?

What state did the patient travel to

What country did the patient travel to

When did the trip begin

When did the trip end

Date Symptoms began

Date patient hospitalized

Date patient died

What rabies virus variant was responsible for the infection

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_City\_USGS\_GNIS

PHVS\_State\_FIPS\_5-2

PHVS\_Country\_ISO\_3166-1

PHVS\_Occupation\_CDC

PHVS\_Sex\_MFU

PHVS\_RaceCategory\_CDC\_Unk

PHVS\_EthnicityGroup\_CDC\_Unk

PHVS\_YesNoUnknown\_CDC

PHVS\_AnimalSpecies\_AnimalRabies

PHVS\_State\_FIPS\_5-2

PHVS\_Country\_ISO\_3166-1

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_State\_FIPS\_5-2

PHVS\_Country\_ISO\_3166-1

PHVS\_VirusVariantType\_AnimalRabies

Label/Short Name

Long Term Care Facility Resident

Culture Date

Bacterial Infection Syndrome

Sterile Specimen Type

Did Underlying Condition(s) exist?

Underlying Condition(s)

Oxacillin Zone Size

Oxacillin Interpretation

Antimicrobial Agent

Antimicrobial Susceptibility Test  
Method

Antimicrobial Susceptibility Test  
Result

Minimum Inhibitory Concentration  
Range

Serotyping Results Available

Lab Result Coded Value

Serotype Method

23-Valent Pneumo Poly Vaccine

7-Valent Pneumo Conjugate Vaccine

13-Valent Pneumo Conjugate  
Vaccine

Vaccine Administered

Vaccine Manufacturer

Vaccine Lot Number

Vaccine Administered Date

Clinical syndrome

Method(s) of laboratory testing

Name of CIDT test and manufacturer

CLIA number of laboratory

In Day Care

Underlying Condition(s)

Underlying Conditions Indicator

Illness Onset Age

Illness Onset Age Units

Hospital ICU

Residence

Pregnancy Status at the Time of First  
Positive Culture

Pregnancy Outcome  
Gestational Age  
Birth Weight  
Birth Weight Units  
Premature Infant  
Insurance  
Epi-Linked to a Laboratory-  
Confirmed or Probable Case  
ABCs Case  
ABCs State ID  
Recurrent Disease with Same  
Pathogen

Previous State ID (Recurrent Case)  
Laboratory Testing Performed  
Laboratory Confirmed  
Test Manufacturer  
Lab Accession Number  
Did the Subject Ever Receive a  
Vaccine Against This Disease  
Date of Last Dose Prior to Illness  
Onset  
Vaccination Doses Prior to Onset  
Vaccine History Comments  
Age at Vaccination  
Age at Vaccination Units  
Vaccine History Information Source  
Vaccine Information Source Indicator  
  
Susceptibility Test

## Description

Does the patient reside in a long term care facility?

Date the first positive culture was obtained.

Types of infection(s) that are caused by the bacterial organism.

Sterile body site(s) from which the organism was isolated.

Did the subject have any pre-existing medical conditions before the start of the illness/condition?

Listing of pre-existing conditions as related to the condition/illness

Oxacillin zone size for cases of *Streptococcus pneumoniae*

Oxacillin interpretation for cases of *Streptococcus pneumoniae*

Antimicrobial agent tested

Antimicrobial susceptibility testing method used

S/I/R/U result, indicating whether the microorganism is susceptible or not susceptible (intermediate or resistant) to the antimicrobial being tested.

MIC (minimum inhibitory concentration) range.

Are serotyping results available for *S pneumoniae* isolate?

If Serotyping results are available for *S pneumoniae* isolate, please specify.

Serotyping Method Used

Has patient  $\geq 2$  yrs received 23-valent pneumococcal polysaccharide vaccine (Pneumovax)?

If less than eighteen years of age, did the patient receive 7-valent pneumococcal conjugate vaccine (PCV7 or Prevnar)?

If less than eighteen years of age, did the patient receive 13-valent pneumococcal conjugate vaccine (PCV13)?

The type of vaccine administered

Manufacturer of the vaccine

The vaccine lot number of the vaccine administered

The date that the vaccine was administered

Clinical diagnoses associated with a case of IPD

Type of laboratory test used to diagnose pneumococcal infection from a sterile site isolate

Name of culture independent laboratory test used and manufacturer of the test

CLIA number of the laboratory that conducted the testing

Does this patient attend a day care facility?

Listing of underlying causes or prior illnesses

Underlying Conditions Indicator

Illness onset age

Illness onset age units

During any part of the hospitalization, did the subject stay in an Intensive Care Unit (ICU) or a Critical Care Unit (CCU)?

Where was the patient a resident at time of initial culture?

At the time of first positive culture, was the patient pregnant or postpartum? (The postpartum period is defined as the 30 days following a delivery or miscarriage)

If pregnant or postpartum, what was the outcome of fetus?  
If patient <1 month of age, indicate gestational age (in weeks)  
If patient <1 month of age, indicate birth Weight  
Birth Weight Units  
Premature at birth (for children  $\leq 2$  years old)  
Insurance  
Is this case Epi linked to a confirmed or probable case?

ABCs case?

ABCs State ID

Does this case have recurrent disease with the same pathogen? (For *Streptococcus pneumoniae*, the specimen from the current case must have been isolated 8 or more days after any previous case due to the same pathogen. For all other pathogens, the specimen from the current case must have been isolated 30 or more days after any previous case due to the same pathogen.)

StateID of 1st occurrence for this pathogen and person.

Was laboratory testing done to confirm the diagnosis?

Was the case laboratory confirmed?

Test Manufacturer

Lab Accession Number (including CDC Lab ID)

Did the subject ever receive a vaccine against this disease?

Date of last vaccine dose against this disease prior to illness onset

Number of vaccine doses against this disease prior to illness onset

Vaccine History Comments

The persons age at the time the vaccine was given

The age units of the person at the time the vaccine was given

What sources were used for vaccination history?

Vaccination History Information Source Indicator

Was any susceptibility data available?

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority

PHVS\_YesNoUnknown\_CDC

PHVS\_BacterialInfectionSyndrome\_IPD

PHVS\_SterileSpecimen\_IPD

PHVS\_YesNoUnknown\_CDC

PHVS\_UnderlyingConditions\_IPD

PHVS\_OxacillinInterpretation\_IPD

PHVS\_AntimicrobialAgent\_IPD

PHVS\_AntimicrobialSuptibilityTestMethod\_IPD

PHVS\_SusceptibilityResult\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_SerotypeMethod\_IPD

PHVS\_SerotypeMethod\_IPD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_VaccinesAdministeredCVX\_CDC\_NIP

PHVS\_ManufacturersOfVaccinesMVX\_CDC\_NIP

PHVS\_YesNoUnknown\_CDC

P

PHVS\_UnderlyingConditions\_RIBD

P

PHVS\_YesNoUnknown\_CDC

P

N/A

P

PHVS\_AgeUnit\_UCUM

P

PHVS\_YesNoUnknown\_CDC

P

PHVS\_ResidenceLocation\_RIBD

P

PHVS\_PregnacyStatus\_RIBD

P

|                             |   |
|-----------------------------|---|
| PHVS_FetalOutcome_RIBD      | P |
| N/A                         | P |
| N/A                         | P |
| PHVS_WeightUnit_UCUM        | P |
| PHVS_YesNoUnknown_CDC       | P |
| PHVS_InsuranceType_RIBD     | P |
| PHVS_YesNoUnknown_CDC       | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_AgeUnit_UCUM           | P |
| PHVS_InformationSource_RIBD | P |
| PHVS_YesNoUnknown_CDC       | P |
| PHVS_YesNoUnknown_CDC       | P |

Label/Short Name

Diagnosis

Hospitalization for treatment

Admission date

Hospital name

Hospital address

Illness outcome

Nights away from home

Accommodation name

Accommodation address

Accommodation city

Accommodation state

Accommodation zip

Accommodation country

Accommodation room number

Arrival Date

Departure Date

Reported CDC

Whirlpool/Spa vicinity

Respiratory therapy equipment use

Humidifier use

Water type

Healthcare setting visit/stay

Healthcare setting/facility

Exposure type

Facility name

Transplant center

Visit reason

HC facility city

HC facility state

Admission date

End date

Healthcare exposure

Assisted living facility exposure

AL facility type

AL exposure type

AL facility name

AL city

AL state

AL start date

AL end date  
Urine Ag positive  
Urine Ag collection date  
Culture positive  
Culture collection date  
Culture site  
Culture species  
Culture serogroup  
Ab titer  
Acute titer  
Acute collected  
Convalescent titer  
Convalescent collected  
Ab titer other

Acute titer other  
Acute collected other

Convalescent titer other  
Convalescent collected other

Species other  
Serogroup other  
DFA/IHC positive  
DFA/IHC collection date  
DFA/IHV specimen site  
Species other - DFA/IHC  
Serogroup other - DFA/IHC  
Nucleic Acid Assay - other  
Nucleic Acid Assay collection date  
Nucleic Acid Assay specimen site  
Species other - nucleic acid assay  
Serogroup other - nucleic acid assay

Whirlpool Spa, Location  
Whirlpool Spa, Dates  
Occupation  
Interviewer's Name  
Interviewer's Affiliation  
Interviewer's telephone number  
Name of State Health Department  
Official who reviewed this report  
Title of State Health Department  
Official who reviewed this report  
Telephone Number of State Health  
Department Official who reviewed  
this report

Illness Onset Age  
Illness Onset Age Units  
Accommodation Comments  
Address of Healthcare Facility  
  
Zip Code of Healthcare Facility  
Healthcare Setting Exposure  
Comments  
  
Healthcare Facility Water  
Management Program  
  
Street Address of Assisted/Senior  
Living Facility  
  
Zip Code of Assisted/Senior Living  
Facility  
  
Assisted/Senior Living Facility  
Comments  
  
Assisted/Senior Living Facility Water  
Management Program  
  
Exposure  
Exposure Indicator  
Location of Exposure  
Date(s) of Exposure  
Recent Cruise Travel  
Name of Cruiseline  
Name of Ship  
Cruise Departure City  
Cruise Departure State  
Cruise Departure Country  
Date of Cruise Departure  
Cruise Return City  
Cruise Return State  
Cruise Return Country  
Date of Cruise Return  
Cabin Number  
Port of Call City  
Port of Call Country  
Port of Call State  
Port of Call Date  
CDC NORS Outbreak ID#  
Did Underlying Condition(s) Exist  
Underlying Condition(s)  
Underlying Conditions Indicator  
Titer Test Type  
  
Test Manufacturer  
Test Brand Name

## Description

Disease caused by a Legionella species

Was patient hospitalized during treatment for legionellosis?

Date of admission to hospital

Name of hospital to which admitted

City and state of hospital

Outcome of illness

In the 10 days before onset, did the patient spend any nights away from home (excluding healthcare settings)?

Name of lodging where patient stayed other than usual resident

Address of lodging away from home

City of lodging away from home

State of lodging away from home

Zipcode of lodging away from home

Country of lodging away from home

Room number at lodging where patient stayed other than usual resident

Date of stay arrival

Date of stay departure

If yes, was this case reported to CDC at [travellegionella@cdc.gov](mailto:travellegionella@cdc.gov)? 1

In the 10 days before onset, did the patient get in or spend time near a whirlpool spa (i.e., hot tub)?

In the 10 days before onset, did the patient use a nebulizer, CPAP, BiPAP or any other respiratory therapy equipment for the treatment of sleep apnea, COPD, asthma or for any other reason?

If yes, does this device use a humidifier?

If yes, what type of water is used in the device? This is a multi-select field.

In the 10 days before onset, did the patient visit or stay in a healthcare setting (e.g., hospital, long term care/rehab/skilled nursing facility, clinic)?

Type of healthcare setting/facility

Type of exposure in HC setting/facility

Name of healthcare facility

Is this a transplant center?

Reason for visit to HC facility

City of HC facility

State of HC facility

Start date of HC facility admission/visit

End date of HC facility admission/visit

Was this case associated with a healthcare exposure?

In the 10 days before onset, did the patient visit or stay in an assisted living facility or senior living facility?

Type of assisted living facility exposure

Type of assisted living facility

Name of AL facility

Name of city of AL facility

Name of state of AL facility

Start date of AL facility admission/visit

End date of AL facility admission/visit  
Was the urine antigen positive?  
Date urine antigen was collected  
Was the culture positive?  
Date culture was collected  
Site of culture specimen  
Species isolated from culture  
Serogroup of species from culture  
Was there a fourfold rise in Ab titer?  
Initial Ab titer to L. pneumophila serogroup 1  
Initial Ab titer specimen collection date  
Convalescent Ab titer to L. pneumophila serogroup 1  
Convalescent Ab specimen collection date  
Was there a fourfold rise in Ab titer for other than L. pneumophila serogroup 1 or to multiple species or serogroups of Legionella using pooled antigen?  
Initial Ab titer to other than L. pneumophila serogroup 1  
Initial Ab titer specimen collection date for species other than L. pneumophila serogroup 1  
Convalescent Ab titer to species other than L. pneumophila serogroup 1  
Convalescent Ab specimen collection date for species other than L. pneumophila serogroup 1  
Species identified for other than L. pneumophila serogroup 1  
Serogroup identified for other than L. pneumophila serogroup 1  
Was the DFA or IHC positive?  
Date specimen for DFA/IHC collected  
Site of DFA/IHC specimen  
Species identified by DFA/IHC for other than L. pneumophila serogroup 1  
Serogroup identified by DFA/IHC for other than L. pneumophila serogroup 1  
Was a nucleic acid assay (e.g., PCR) performed?  
Date nucleic acid assay specimen collected  
Site of nucleic acid assay specimen  
Species identified by nucleic acid assay for other than L. pneumophila serogroup 1  
Serogroup identified by nucleic acid assay for other than L. pneumophila serogroup 1

If Yes, describe where

If Yes, list dates

Subject's Occupation

Interviewer's Name

Interviewer's Affiliation

Interviewer's telephone number

Name of State Health Department Official who reviewed this report

Title of State Health Department Official who reviewed this report

Telephone Number of State Health Department Official who reviewed this report

Age at illness onset

Age units at illness onset

Comments or information about nights away from home not collected elsewhere

Street Address of healthcare facility visited by the patient in the 10 days before onset

Zip code of healthcare facility visited by the patient in the 10 days before onset

Comments or information about healthcare setting exposure not collected elsewhere

Did the healthcare facility have a water management program to reduce the risk of Legionella growth and spread in place?

Street address of assisted/senior living facility visited/lived in by the patient during exposure

Zip code of assisted/senior living facility visited/lived in by the patient during exposure

Comments or information about assisted/senior living facility exposure not collected elsewhere

Did the assisted/senior living facility have a water management program to reduce the risk of Legionella growth and spread in place?

Was the patient exposed to any of the following during the 10 days prior to onset?

Exposure Indicator

Location of exposure (e.g. facility name, city , state)

Date(s) of exposure

In the 10 days before onset, did patient take a cruise?

Name of cruiseline patient sailed with

Name of ship patient sailed on

Cruise departure city

Cruise departure state

Cruise departure country

Cruise departure date

Cruise return city

Cruise return state

Cruise return country

Cruise return date

Patient's cruise ship cabin number

Port of call city

Port of call country

Port of call state

Date for port of call

CDC National Outbreak Reporting System (NORS) Outbreak ID#

Did the patient have any underlying causes or prior illnesses?

Listing of underlying causes or prior illnesses

Underlying conditions indicator

If this is a titer, indicate if this is an initial/acute or convalescent titer (Titer Test Type)

Test Manufacturer

Test Brand Name

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority

|                                |   |
|--------------------------------|---|
| N/A                            | P |
| PHVS_AgeUnit_UCUM              | P |
| N/A                            | P |
| N/A                            | P |
| N/A                            | P |
| N/A                            | P |
| N/A                            | P |
| PHVS_YesNoUnknown_CDC          | P |
| N/A                            | P |
| N/A                            | P |
| N/A                            | P |
| PHVS_YesNoUnknown_CDC          | P |
| PHVS_LegionellaExposure_RIBD   | P |
| PHVS_YesNoUnknown_CDC          | P |
| N/A                            | P |
| N/A                            | P |
| PHVS_YesNoUnknown_CDC          | P |
| PHVS_CruiseLine_RIBD           | P |
| N/A                            | P |
| N/A                            | P |
| PHVS_State_FIPS_5-2            | P |
| PHVS_Country_ISO_3166-1        | P |
| N/A                            | P |
| N/A                            | P |
| PHVS_State_FIPS_5-2            | P |
| PHVS_Country_ISO_3166-1        | P |
| N/A                            | P |
| N/A                            | P |
| N/A                            | P |
| PHVS_Country_ISO_3166-1        | P |
| PHVS_State_FIPS_5-2            | P |
| N/A                            | P |
| N/A                            | P |
| PHVS_YesNoUnknown_CDC          | P |
| PHVS_UnderlyingConditions_RIBD | P |
| PHVS_YesNoUnknown_CDC          | P |
| PHVS_TiterTestType_RIBD        | P |
| N/A                            | P |
| N/A                            | P |

Label/Short Name

Date First Submitted

State Case ID

Health care provider

Health care provider phone

Case Class Status Code

Subject Address State

Subject Address ZIP Code

Subject Address County

Subject's Sex

Date of Birth

Age at case investigation

Age units at case investigation

Ethnic Group Code

Race Category

Symptomatic

Date symptom onset

Symptoms

Hospitalization?

Admission Date

Number of days

Outcome

Discharge Date

Deceased Date

Antibiotics prescribed

Antibiotics start date

Doxycycline

Penicillin

Other antibiotics

Reporting Lab Name

Date Sample Received at Lab

Date specimen collected

Specimen Type

Date of Acute Specimen Collection

Date of Convalescent Specimen  
Collection

Resulted Test Name

Numeric Result

Result Units

Coded Result Value

Organism Name

Lab Result Text Value

Result Status

Specimens to CDC

Exposures

Animal contact

Livestock contact

Wildlife contact

Animal contact other

Animal contact location

Water contact

Water contact other

Water contact location

Contact Type

Occupational contact

Occupational contact other

Recreational contact

Recreational contact other

Avocational contact

Avocational contact other

Contact Type Other

Rodent infested housing

Rural residence

Hisotry of leptospirosis

Travel

Travel location

Rainfall

Flooding

Similar illness

Outbreak

Case Outbreak Name

Person Reporting to CDC - Name

Person Reporting to CDC - Phone  
Number

Number of Weeks Gestation at Onset  
of Illness

Pregnancy Adverse Outcome

Clinical Manifestation Indicator

Medication

Hospital Procedure

Sick Animal

Sick Animal Specified

Drinking or Bathing Usage

Treated Well Water or Rainwater

Flooding Location

Pre-existing conditions

Work Location State

Work Location City

Work Location Zip

Open Wounds

Type of Rodent

Highest Titer Serovar(s)

Contact with Sewage

Activity Type

Exposure Location City

Exposure Location State

Exposure Location Country

Exposure Location

Patient Address City

Immunocompromised Associated  
Condition or Treatment

Days Missed Due to Illness

Container Lid

Rodent Location

Travel Outside USA Prior to Illness

Onset within Program Specific  
Timeframe

Did the Case Travel Domestically  
Prior to Illness Onset

Specify Different Travel Exposure  
Window

International Destination(s) of  
Recent Travel

Travel State

Date of Arrival to Travel Destination

Date of Departure from Travel  
Destination

**Congregant Living Setting**

**Homelessness**

## Description

Date/time the notification was first sent to CDC. This value does not change after the original notification.

States use this field to link NEDSS investigations back to their own state investigations.

Health care provider name

Health care provider phone number

Status of the case/event as suspect, probable, confirmed, or not a case per CSTE/CDC/surveillance case definitions.

State of residence of the subject

ZIP Code of residence of the subject

County of residence of the subject

Subject's current sex

Birth Date (mm/yyyy)

Subject age at time of case investigation

Subject age units at time of case investigation

Based on the self-identity of the subject as Hispanic or Latino

Field containing one or more codes that broadly refer to the subject's race(s).

Was the case-patient symptomatic?

If Symptomatic was "Yes", provide the Date of Onset of symptoms

Select symptoms and signs reported or identified, from "Fever", "Myalgia", "Headache", "Jaundice", "Hepatitis", "Conjunctival suffusion", "Rash (Maculopapular or petechial)", "Aseptic meningitis", "Gastrointestinal involvement", "Pulmonary complications", "Cardiac involvement", "Renal insufficiency/failure", "Hemorrhage", "Other (specify)"

Was the case-patient hospitalized (at least overnight) for this Did the case-patient die?

Yes No Unk infection?

Subject's first admission date to the hospital for the condition covered by the investigation.

If hospitalized, number of days.

Clinical outcome of the patient ("Still hospitalized"; "Discharged"; "Died"; "Other")

Subject's first discharge date from the hospital for the condition covered by the investigation.

If the subject died from this illness or complications associated with this illness, indicate the date of death

Were Antibiotics prescribed for this infection?

Date started taking antibiotics

Was doxycycline prescribed for this infection?

Was penicillin prescribed for this infection?

List other antibiotics prescribed for this infection

Name of Laboratory that reported test result.

Date Sample Received at Lab (accession date).

The date the specimen was collected.

Type of specimen collected ("Blood", "Urine", "Tissue", "CSF", "Other", "Unknown", "Serum")

The date the acute specimen was collected.

The date the convalescent specimen was collected.

The lab test that was run on the specimen ("Microscopic Agglutination Test (MAT)", "PCR", "Culture", "Immunofluorescence", "Darkfield microscopy", "ELISA (specify)", "IHC", "Other, specify")

Results expressed as numeric value/quantitative result.

The unit of measure for numeric result value.

Coded qualitative result value (e.g., Positive, Negative).

The Organism (i.e., species and serovar) name as a test result. This element is used when the result was reported as an organism.

Textual result value, used if result is neither numeric nor coded.

The Result Status is the degree of completion of the lab test.

Were specimens or isolates sent to CDC for testing?

Describe exposures to water, animals, or wet soil which the subject had in the 30 days prior to illness onset

Select which animals the subject has had contact with in the 30 days prior to illness onset, if any ("Farm livestock", "Wildlife", "Dogs", "Rodents", "Other", "No known contact", "Unknown")

If the subject had contact with livestock, specify the animal(s)

If the subject had contact with wildlife, specify the animal(s)

If animal contact is "Other", describe the animal(s) with which the subject has had contact

If the subject had contact with animals, specify the geographic location where the contact occurred

Select which water sources the subject has had contact with in the 30 days prior to illness onset, if any ("Standing fresh water (lake, pond, run-off)", "Flood water", "River", "Wet soil", "Sewage", "Water sports", "Other", "No known contact", "Unknown")

If water contact is "Other", describe the water source(s) which the subject has had contact

If the subject had contact with water, specify the geographic location where the contact occurred

If subject had contact with animals, fresh water, or wet soil in the 30 days prior to illness onset, describe the type of contact ("Occupational", "Recreational", "Avocational", "Other")

If type of contact with animals or water is "Occupational", select the occupational group ("Farmer (land)", "Farmer (animals)", "Fish worker", "Other", "Unknown")

If the occupational group through which the subject had contact with animals or water is "Other", describe the occupation

If type of contact with animals or water is "Recreational", select the recreational activity ("Swimming", "Boating", "Outdoor competition", "Camping/hiking", "Hunting", "Other", "Unknown")

If the recreational activity through which the subject had contact with animals or water is "Other", describe the recreational activity

If type of contact with animals or water is "Avocational", select the activity ("Gardening", "Pet-ownership", "Other", "Unknown")

If the Avocational activity through which the subject had contact with animals or water is "Other", describe the avocational activity

If Contact Type is "Other", describe the type of contact with animals, wet soil, or standing water

Did the patient stay in housing with evidence of rodents in the 30 days prior to illness onset

Residence in rural area in the 30 days prior to illness onset

Does the subject have a history of leptospirosis?

Did the subject travel out of the county, state, or country in the 30 days prior to symptom onset?

If the travel is "Yes", provide location(s) of travel in the 30 days prior to symptom onset

Was there heavy rainfall near the subjects place of residence, worksite, activities, or travel in the 30 days prior to symptom onset?

Was there flooding near the subjects place of residence, worksite, activities, or travel in the 30 days prior to symptom onset?

Did the patient have similar exposures as a contact diagnosed with leptospirosis in the 30 day period

Is this patient part of an outbreak?

A state-assigned name for an identified outbreak.

Name of the person who is reporting the case to the CDC. This is the person that CDC should contact in a state if there are questions regarding this case notification.

Phone Number of the person who is reporting the case to the CDC. This is the person that CDC should contact in a state if there are questions regarding this case notification.

If subject was pregnant at time of illness onset, specify the number of weeks gestation at onset of illness (1-45 weeks)

If subject was pregnant at time of illness, did the subject have any adverse outcome to the pregnancy (e.g. miscarriage, stillbirth, neonatal illness or death) related to the illness?

For each clinical manifestation reported, indicate (YNU) whether the subject developed the specified manifestation as a result of the illness.

What antibiotics were prescribed/administered to the patient for treatment of this illness?

If subject was hospitalized, were any of the following procedures or treatments done?

Were any animals sick at the time of contact?

Specify the sick animal/s the patient had contact with at this location

Did the subject use well water or rainwater collected in cisterns, drums, or other containers for drinking or bathing?

If the subject used well water or collected rainwater for drinking or bathing, was the water boiled, chemically treated, or UV treated prior to use?

Flooding Location

Does the patient have any of the following pre-existing medical conditions?

Indicate the state where the subject's workplace is located

Indicate the city where the subject's workplace is located

Indicate the zip code where the subject's workplace is located

Did the subject have any open wounds or cuts in the 30 days prior to illness onset?

If the subject saw rodents in the 30 days prior to illness onset, what type of rodent(s) were seen?

If the Microscopic Agglutination Test (MAT) was performed, specify the serovar(s) with the highest titer.

Did the subject have contact with sewage in the 30 days prior to illness onset?

Indicate the types of activity that led to the selected animal, water or mud contact. Multiple activities can be selected for the type of exposure.

Indicate the county where the selected exposure occurred

Indicate the state where the selected exposure occurred

Indicate the country where the selected exposure occurred

Indicate the specific location where exposure occurred (e.g. home, work, name of park, name of lake)

Patient Address City

If the patient has an immunosuppressive condition, specify the condition.

Number of days of work or school the patient missed due to this illness?

If the subject had contact with well water, cistern water, or rainwater collected in a drum or other container, did the well, cistern or other container have a lid?

Where did the subject see rodents or evidence of rodents?

Did the subject travel internationally in the six months prior to illness onset?

Did the subject travel domestically in the six months prior to illness onset?

If the travel exposure window used by the jurisdiction is different from that stated in the travel exposure questions, specify the time interval in days here. Otherwise, leave blank.

International destination or countries the subject traveled to

Domestic destination, state(s) traveled to

Date of arrival to travel destination

Date of departure from travel destination

**In the 30 days prior to illness onset, did the subject ever reside in any of these congregate living settings:**

**In the 30 days prior to illness onset, did the subject ever sleep in:**

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_CaseClassStatus\_NND

PHVS\_State\_FIPS\_5-2

PHVS\_County\_FIPS\_6-4

PHVS\_AgeUnit\_UCUM\_NETSS

PHVS\_EthnicityGroup\_CDC\_Unk

PHVS\_RaceCategory\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_UnitsOfMeasure\_CDC  
PHVS\_PosNegUnk\_CDC

PHVS\_Microorganism\_CDC

PHVS\_ObservationResultStatus\_HL7\_2x  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

N/A

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

N/A

PHVS\_YesNoUnknown\_CDC  
N/A

PHVS\_YesNoUnknown\_CDC

TBD

Specify the location where flooding occurred  
TBD  
PHVS\_State\_FIPS\_5-2  
N/A



N/A  
PHVS\_YesNoUnknown\_CDC

TBD

N/A  
PHVS\_YesNoUnknown\_CDC  
TBD

N/A  
PHVS\_State\_FIPS\_5-2  
N/A  
N/A

N/A  
N/A  
N/A  
PHVS\_YesNoUnknown\_CDC

TBD  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

N/A

PHVS\_Country\_ISO\_3166-1

PHVS\_State\_FIPS\_5-2  
N/A

N/A

**TBD**

**TBD**



CDC Priority (New)

TBD

TBD

TBD

TBD

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TBD

2  
3

3  
3

3

2

2

3

2  
2

3

3

3  
2

Label/Short Name

CasId  
CdId  
ReportStatus  
FormVersion  
FoodNetID  
CaseStateID  
CaseLocalID  
Interviewer  
SentLab  
SentLabSpecify  
DateCompletedBy  
Gender  
City  
ResidenceCounty  
State of Residence  
Age  
DateOfBirth  
Ethnicity  
HispanicMexican  
HispanicPuertoRican  
HispanicCuban  
HispanicOther  
HispanicSpecify  
HispanicUnknown  
RaceAfricanAmerican\_Black  
RaceAsian  
RaceAsianIndian  
RaceAsianChinese  
RaceAsianFilipino  
RaceAsianJapanese  
RaceAsianKorean  
RaceAsianVietnamese  
RaceAsianOther  
RaceAsianOtherSpecify  
RaceNativeHawaiian\_OtherPacificIsla  
RacePacificIslanderHawaiian  
RacePacificIslanderGuamanian  
RacePacificIslanderSomoan  
RacePacificIslanderOther  
RaceNativeAmerican  
RaceWhite  
RaceWhiteMidEast  
RaceWhiteNotMidEast  
RaceUnknown  
RaceOther

RaceOtherSpecify  
RaceDecline  
Pregnancy  
BloodNP  
BloodNPDate  
BloodNPIDNumber  
CSFNP  
CSFNPDate  
CSFNPIDNumber  
OtherNP  
OtherNPSpec  
OtherNPDate  
OtherNPIDNumber  
OtherNP2  
OtherNP2Spec  
OtherNP2Date  
OtherNP2IDNumber  
NPSpecimenFlag  
BacteremiaNP  
MeningitisNP  
NpListerialIllnessMeningo  
FebrileGastroenteritisNP  
NpListerialIllnessBrain  
NpListerialIllnessRhomb  
NpListerialIllnessPer  
NpListerialIllnessPneu  
NpListerialIllnessWound  
NpListerialIllnessJoint  
NpListerialIllnessBone  
OtherIllnessNP  
OtherIllnessNPSpec  
UnknownNP  
HospitalizedNP  
AdmitNP  
DischargeNP  
StillhospitalizedNP  
NPHospitalizedListeriosisStillDate  
OutcomeNP  
NPOutcomeDied  
NPOutcomeListeriosisDeathCert  
NPOutcomeLastAlive  
BloodMotherAP  
BloodMotherAPDate  
BloodMotherAPIDNumber  
BloodNeonateAP  
BloodNeonateAPDate  
BloodNeonateAPIDNumber

CSFMotherAP  
CSFMotherAPDate  
CSFMotherAPIDNumber  
CSFNeonateAP  
CSFNeonateAPDate  
CSFNeonateAPIDNumber  
PlacentaAP  
PlacentaAPDate  
PlacentaAPIDNumber  
AmnioticAP  
AmnioticAPDate  
AmnioticAPIDNumber  
PrSpecimenTypeFetal  
PrSpecimenCollectionFetal  
PrSpecimenIsolateIDFetal  
OtherAP  
OtherAPSpec  
OtherAPDate  
OtherAPIDNumber  
Other2AP  
Other2APSpec  
Other2APDate  
Other2APIDNumber  
APSpecimenFlag  
OutsideUSSpecify  
BornInUS  
OutsideUS  
PrimaryLanguage  
PrimaryLanguageSpecify  
YearCametoUS  
CDC\_EFORSID  
BloodNPLab  
CSFNPLab  
OtherNP2Lab  
OtherNPLab  
StoolNP  
StoolNPDate  
StoolNPLab  
StoolNPIDNumber  
BloodMotherAPLab  
BloodNeonateAPLab  
CSFMotherAPLab  
CSFNeonateAPLab  
StoolMotherAP  
StoolMotherAPDate  
StoolMotherAPLab  
StoolMotherAPIDNumber

PlacentaAPLab  
AmnioticAPLab  
OtherAPLab  
None  
Cancer  
Leukemia  
Lymphoma  
Hodgkins  
NonHodgkins  
MultipleMyeloma  
Myeloproliferative  
OtherCancer  
OtherCancerSpecify  
KidneyDialysis  
CirrhosisLiverDisease  
COPD  
HeartDisease  
HeartDiseaseSpecify  
OrganTransplant  
OrganTransplantSpecify  
Unknown  
OtherConditions  
Crohns  
Diabetes  
DiabetesTypel  
DiabetesTypell  
GiantCell  
Hemochromatosis  
HIV\_AIDS  
HIV  
AIDS  
Lupus  
RheumatoidArthritis  
Sarcoidosis  
SickleCell  
Splenectomy  
UlcerativeColitis  
Other1  
Other1Spec  
Cond\_Pregnancy  
ImmunosuppressiveMed  
Steroids  
CancerChemotherapy  
OtherImmunosuppressive  
OtherImmunoSpecify  
Alcohol  
IDU

Antacids  
AntacidsSpecify  
InterviewPatientAble  
InterviewPatientReason  
InterviewPatientReasonSpecify  
StomachUlcers  
Arthritis  
KidneyDisease  
StomachSurgery  
Hypertension  
ESRD  
ChronicDiarrhea  
Comments  
Underlying  
Radiation  
Antibiotics  
Other2  
Other3  
Other4  
Other5  
Other2Spec  
Other3Spec  
Other4Spec  
Other5Spec  
PrInfant1PregnancyOutcome  
PrInfant1GestationWeeks  
PrInfant1DeliveryType  
PrInfant1PregnancyOutcomeDate  
PrInfant1PregnancyOutcomeOtherSpec  
PrInfant2PregnancyOutcome  
PrInfant2GestationWeeks  
PrInfant2DeliveryType  
PrInfant2PregnancyOutcomeDate  
PrInfant2PregnancyOutcomeOtherSpec  
PrMotherIllnessFever  
PrMotherIllnessBacteremia  
PrMotherIllnessMeningitis  
PrMotherIllnessAmnionitis  
PrMotherIllnessFlu  
PrMotherIllnessNone  
PrMotherIllnessOther  
PrMotherIllnessOtherSpecify  
PrMotherIllnessUnknown  
PrMotherHospLst  
PrMotherHospListAdmit  
PrMotherHospDischarge  
PrMotherHospListStill

PrMotherHospListHospital  
PrMotherOutcomeSurvived  
PrMotherOutcomeLastAlive  
PrMotherOutcomeDeathCert  
PrInfant1IllnessBacteremia  
PrInfant1IllnessMeningitis  
PrInfant1IllnessPneumonia  
PrInfant1IllnessNone  
PrInfant1IllnessOther  
PrInfant1IllnessSpecify  
PrInfant1IllnessUnknown  
PrInfant1Delivered  
PrInfant1DeliveredAdmit  
PrInfant1DeliveredDischarge  
PrInfant1DeliveredStill  
PrInfant1DeliveredHospital  
PrInfant1OutcomeSpecify  
PrInfant1HospList  
PrInfant1HospListAdmit  
PrInfant1HospListDischarge  
PrInfant1HospStill  
PrInfant1OutcomeSurvived  
PrInfant1OutcomeLastAlive  
PrInfant1OutcomeDeathCert  
PrInfant2IllnessBacteremia  
PrInfant2IllnessMeningitis  
PrInfant2IllnessPneumonia  
PrInfant2IllnessNone  
PrInfant2IllnessOther  
PrInfant2IllnessSpecify  
PrInfant2IllnessUnknown  
PrInfant2Delivered  
PrInfant2DeliveredAdmit  
PrInfant2DeliveredDischarge  
PrInfant2DeliveredStill  
PrInfant2DeliveredHospital  
PrInfant2OutcomeSpecify  
PrInfant2HospList  
PrInfant2HospListAdmit  
PrInfant2HospListDischarge  
PrInfant2HospListStill  
PrInfant2OutcomeSurvived  
PrInfant2OutcomeLastAlive  
PrInfant2OutcomeDeathCert  
PrMotherIllnessGastroenteritis  
PrInfant1IllnessGranulomatosis  
PrInfant2IllnessGranulomatosis

InterviewDate  
Interviewee  
Relationship  
OtherRelationshipSpecify  
Onset  
IllnessBeginNotApplicable  
HospitalizedBefore  
HAdmit  
HDischarge  
Hname  
StillHosp  
NursingHomeBefore  
Admitdate  
DischargeDate  
StillHosporNH  
NHName  
TravelState  
StatesVisited  
TravelInternat  
Countries  
DateDepart  
DateReturn  
Fever  
Chills  
Diarrhea  
Vomiting  
PretermLabor  
MuscleAches  
Headache  
StiffNeck  
AlteredMental  
OtherSx1  
OtherSx1Specify  
OtherSx2  
OtherSx2Specify  
OtherSxFlag  
TestDelivered  
\_4weeksbefore  
SpecCollection  
HasAllergies  
Milk  
Eggs  
Peanuts  
TreeNuts  
Fish  
Soy  
Wheat

Shellfish  
OtherAllergy  
AllergySpecify  
HadVegetarianDiet  
Vegetarian  
Vegan  
HadRestrictedDiet  
DietDescription  
Grocery1  
Grocery1Address  
Grocery2  
Grocery2Address  
Grocery3  
Grocery3Address  
Grocery4  
Grocery4Address  
Grocery5  
Grocery5Address  
Grocery6  
Grocery6Address  
Grocery7  
Grocery7Address  
GroceryFlag  
ShopperCardReleased  
ShopperCardStoreName1  
ShopperCardNumber1  
ShopperCardStoreName2  
ShopperCardNumber2  
ShopperCardStoreName3  
ShopperCardNumber3  
ShopperCardNameFlag  
Restaurant1  
Restaurant1Address  
RestaurantFoodsAte1  
Restaurant1Date\_1  
Restaurant1Date\_2  
Restaurant1Date\_3  
Restaurant1Date\_4  
Restaurant1Date\_5  
Restaurant2  
Restaurant2Address  
RestaurantFoodsAte2  
Restaurant2Date\_1  
Restaurant2Date\_2  
Restaurant2Date\_3  
Restaurant2Date\_4  
Restaurant2Date\_5

Restaurant3  
Restaurant3Address  
RestaurantFoodsAte3  
Restaurant3Date\_1  
Restaurant3Date\_2  
Restaurant3Date\_3  
Restaurant3Date\_4  
Restaurant3Date\_5  
Restaurant4  
Restaurant4Address  
RestaurantFoodsAte4  
Restaurant4Date\_1  
Restaurant4Date\_2  
Restaurant4Date\_3  
Restaurant4Date\_4  
Restaurant4Date\_5  
Restaurant5  
Restaurant5Address  
RestaurantFoodsAte5  
Restaurant5Date\_1  
Restaurant5Date\_2  
Restaurant5Date\_3  
Restaurant5Date\_4  
Restaurant5Date\_5  
Restaurant6  
Restaurant6Address  
RestaurantFoodsAte6  
Restaurant6Date\_1  
Restaurant6Date\_2  
Restaurant6Date\_3  
Restaurant6Date\_4  
Restaurant6Date\_5  
Restaurant7  
Restaurant7Address  
RestaurantFoodsAte7  
Restaurant7Date\_1  
Restaurant7Date\_2  
Restaurant7Date\_3  
Restaurant7Date\_4  
Restaurant7Date\_5  
RestaurantFlag  
OtherVenue1  
OtherVenue1Address  
OtherLocationFoodsAte1  
OtherVenue1Date\_1  
OtherVenue1Date\_2  
OtherVenue1Date\_3

OtherVenue1Date\_4  
OtherVenue1Date\_5  
OtherVenue2  
OtherVenue2Address  
OtherLocationFoodsAte2  
OtherVenue2Date\_1  
OtherVenue2Date\_2  
OtherVenue2Date\_3  
OtherVenue2Date\_4  
OtherVenue2Date\_5  
OtherVenue3  
OtherVenue3Address  
OtherLocationFoodsAte3  
OtherVenue3Date\_1  
OtherVenue3Date\_2  
OtherVenue3Date\_3  
OtherVenue3Date\_4  
OtherVenue3Date\_5  
OtherVenue4  
OtherVenue4Address  
OtherLocationFoodsAte4  
OtherVenue4Date\_1  
OtherVenue4Date\_2  
OtherVenue4Date\_3  
OtherVenue4Date\_4  
OtherVenue4Date\_5  
OtherVenue5  
OtherVenue5Address  
OtherLocationFoodsAte5  
OtherVenue5Date\_1  
OtherVenue5Date\_2  
OtherVenue5Date\_3  
OtherVenue5Date\_4  
OtherVenue5Date\_5  
OtherVenue6  
OtherVenue6Address  
OtherLocationFoodsAte6  
OtherVenue6Date\_1  
OtherVenue6Date\_2  
OtherVenue6Date\_3  
OtherVenue6Date\_4  
OtherVenue6Date\_5  
OtherVenue7  
OtherVenue7Address  
OtherLocationFoodsAte7  
OtherVenue7Date\_1  
OtherVenue7Date\_2

OtherVenue7Date\_3  
OtherVenue7Date\_4  
OtherVenue7Date\_5  
OtherVenueFlag  
OtherFoodDetails  
SeasonalFoodDetails  
FarmersMarket1  
FarmersMarket1Address  
FarmersMarket2  
FarmersMarket2Address  
FarmersMarket3  
FarmersMarket3Address  
FarmersMarket4  
FarmersMarket4Address  
FarmersMarket5  
FarmersMarket5Address  
FarmersMarket6  
FarmersMarket6Address  
FarmersMarket7  
FarmersMarket7Address  
FarmersMarketPurchase  
GroceryPurchase  
OtherVenuePurchase  
RestaurantPurchase  
InterviewInitials  
FoodComments  
InterviewComments  
IfEatenHam  
DeliSlicedHam  
DetailsHam  
VenueHam  
IfEatenBologna  
DeliSlicedBologna  
DetailsBologna  
VenueBologna  
IfEatenTurkeyBreast  
DeliSlicedTurkeyBreast  
DetailsTurkeyBreast  
VenueTurkeyBreast  
IfEatenChicken  
DeliSlicedChicken  
DetailsChicken  
VenueChicken  
IfEatenRoastBeef  
DeliSlicedRoastBeef  
DetailsRoastBeef  
VenueRoastBeef

IfEatenPastrami  
DeliSlicedPastrami  
DetailsPastrami  
VenuePastrami  
IfEatenLiver  
DeliSlicedLiver  
DetailsLiver  
VenueLiver  
IfEatenPate  
DetailsPate  
VenuePate  
IfEatenHeadCheese  
DeliSlicedHeadCheese  
DetailsHeadCheese  
VenueHeadCheese  
IfEatenPepperoni  
DeliSlicedPepperoni  
DetailsPepperoni  
VenuePepperoni  
IfEatenItalian  
DeliSlicedItalian  
DetailsItalian  
VenueItalian  
IfEatenOtherDeli  
DeliSlicedOtherDeli  
SpecifyOtherDeli  
DetailsOtherDeli  
VenueOtherDeli  
IfEatenDeliMeat  
DeliSlicedDeliMeat  
SpecifyDeliMeat  
DetailsDeliMeat  
VenueDeliMeat  
IfEatenSausage  
DetailsSausage  
VenueSausage  
IfEatenCookedChicken  
DetailsCookedChicken  
VenueCookedChicken  
IfEatenCookedMeat  
DetailsCookedMeat  
VenueCookedMeat  
SpecifyCookedMeat  
IfEatenCured  
DetailsCured  
VenueCured  
IfEatenHotDog

HotDogsHeated  
DetailsHotDog  
VenueHotDog  
IfEatenFrozenPoultry  
DetailsFrozenPoultry  
VenueFrozenPoultry  
SpecifyFrozenPoultry  
IfEatenGroundPoultry  
DetailsGroundPoultry  
VenueGroundPoultry  
SpecifyGroundPoultry  
BolognaOften  
BolognaDeli  
BolognaGrocery  
BolognaOther  
BolognaRestaurant  
VenueBologna2  
VenueBologna3  
VenueBologna4  
DetailsBologna2  
DetailsBologna3  
DetailsBologna4  
ChickenOften  
ChickenDeli  
ChickenGrocery  
ChickenOther  
ChickenRestaurant  
VenueChicken2  
VenueChicken3  
VenueChicken4  
DetailsChicken2  
DetailsChicken3  
DetailsChicken4  
HamOften  
HamDeli  
HamGrocery  
HamOther  
HamRestaurant  
VenueHam2  
VenueHam3  
VenueHam4  
DetailsHam2  
DetailsHam3  
DetailsHam4  
OtherDeliOften  
OtherDeliDeli  
OtherDeliGrocery

OtherDeliOther  
OtherDeliRestaurant  
VenueOtherDeli2  
VenueOtherDeli3  
VenueOtherDeli4  
DetailsOtherDeli2  
DetailsOtherDeli3  
DetailsOtherDeli4  
IfEatenOtherTurkey  
OtherTurkeyOften  
OtherTurkeyDeli  
OtherTurkeyGrocery  
OtherTurkeyOther  
OtherTurkeyRestaurant  
VenueOtherTurkey  
VenueOtherTurkey2  
VenueOtherTurkey3  
VenueOtherTurkey4  
DetailsOtherTurkey  
DetailsOtherTurkey2  
DetailsOtherTurkey3  
DetailsOtherTurkey4  
DeliSlicedOtherTurkey  
PastramiOften  
PastramiDeli  
PastramiGrocery  
PastramiOther  
PastramiRestaurant  
VenuePastrami2  
VenuePastrami3  
VenuePastrami4  
DetailsPastrami2  
DetailsPastrami3  
DetailsPastrami4  
PateOften  
PateDeli  
PateGrocery  
PateOther  
PateRestaurant  
VenuePate2  
VenuePate3  
VenuePate4  
DetailsPate2  
DetailsPate3  
DetailsPate4  
DeliSlicedPate  
TurkeyBreastOften

TurkeyBreastDeli  
TurkeyBreastGrocery  
TurkeyBreastOther  
TurkeyBreastRestaurant  
VenueTurkeyBreast2  
VenueTurkeyBreast3  
VenueTurkeyBreast4  
DetailsTurkeyBreast2  
DetailsTurkeyBreast3  
DetailsTurkeyBreast4  
DeliSlicedHotDog  
HotDogOften  
HotDogDeli  
HotDogGrocery  
HotDogOther  
HotDogRestaurant  
VenueHotDog2  
VenueHotDog3  
VenueHotDog4  
DetailsHotDog2  
DetailsHotDog3  
DetailsHotDog4  
IfEatenSprouts  
DetailsSprouts  
VenueSprouts  
IfEatenBean  
DetailsBean  
VenueBean  
IfEatenAlfalfa  
DetailsAlfalfa  
VenueAlfalfa  
IfEatenClover  
DetailsClover  
VenueClover  
IfEatenRadish  
DetailsRadish  
VenueRadish  
IfEatenBroccoli  
DetailsBroccoli  
VenueBroccoli  
IfEatenMixed  
DetailsMixed  
VenueMixed  
IfEatenOtherSprout  
DetailsOtherSprout  
VenueOtherSprout  
SpecifyOtherSprout

IfEatenCucumber  
DetailsCucumber  
VenueCucumber  
IfEatenPea  
DetailsPea  
VenuePea  
IfEatenSweetPepper  
DetailsSweetPepper  
VenueSweetPepper  
IfEatenHotPepper  
DetailsHotPepper  
VenueHotPepper  
IfEatenScallion  
DetailsScallion  
VenueScallion  
IfEatenCelery  
DetailsCelery  
VenueCelery  
IfEatenCarrot  
DetailsCarrot  
VenueCarrot  
IfEatenMushroom  
DetailsMushroom  
VenueMushroom  
IfEatenPreCutVeg  
SpecifyPreCutVeg  
DetailsPreCutVeg  
VenuePreCutVeg  
IfEatenBasil  
DetailsBasil  
VenueBasil  
IfEatenCilantro  
DetailsCilantro  
VenueCilantro  
IfEatenParsley  
DetailsParsley  
VenueParsley  
IfEatenHerbs  
SpecifyHerbs  
DetailsHerbs  
VenueHerbs  
IfEatenTomato  
DetailsTomato  
VenueTomato  
IfEatenRedRound  
DetailsRedRound  
VenueRedRound

IfEatenRoma  
DetailsRoma  
VenueRoma  
IfEatenCherryTom  
DetailsCherryTom  
VenueCherryTom  
IfEatenVineTom  
DetailsVineTom  
VenueVineTom  
IfEatenOtherTom  
SpecifyOtherTom  
DetailsOtherTom  
VenueOtherTom  
IfEatenLettuce  
BagLettuce  
BagLettuceSpecify  
DetailsLettuce  
VenueLettuce  
IfEatenIceburg  
DetailsIceburg  
VenueIceburg  
IfEatenRomaine  
DetailsRomaine  
VenueRomaine  
IfEatenMesclun  
DetailsMesclun  
VenueMesclun  
IfEatenRadishLettuce  
DetailsRadishLettuce  
VenueRadishLettuce  
IfEatenLeafLettuce  
SpecifyLeafLettuce  
DetailsLeafLettuce  
VenueLeafLettuce  
IfEatenPackedLeafy  
SpecifyPackedLeafy  
DetailsPackedLeafy  
VenuePackedLeafy  
IfEatenSalad  
DetailsSalad  
VenueSalad  
IfEatenProduce  
SpecifyProduce  
DetailsProduce  
VenueProduce  
SproutsOften  
SproutsDeli

SproutsGrocery  
SproutsOther  
SproutsRestaurant  
VenueSprouts2  
VenueSprouts3  
VenueSprouts4  
DetailsSprouts2  
DetailsSprouts3  
DetailsSprouts4  
DeliCounterSprouts  
IfEatenFeta  
DetailsFeta  
RawMilkFeta  
VenueFeta  
IfEatenGoat  
DetailsGoat  
RawMilkGoat  
VenueGoat  
IfEatenBlue  
DetailsBlue  
RawMilkBlue  
VenueBlue  
IfEatenBrie  
DetailsBrie  
RawMilkBrie  
VenueBrie  
IfEatenGouda  
DetailsGouda  
RawMilkGouda  
VenueGouda  
IfEatenShred  
DetailsShred  
RawMilkShred  
VenueShred  
IfEatenMozz  
DetailsMozz  
RawMilkMozz  
VenueMozz  
IfEatenCottage  
DetailsCottage  
RawMilkCottage  
VenueCottage  
IfEatenRicotta  
DetailsRicotta  
RawMilkRicotta  
VenueRicotta  
DetailsGourmet

IfEatenGourmet  
RawMilkGourmet  
VenueGourmet  
IfEatenCheeseDeli  
DetailsCheeseDeli  
RawMilkCheeseDeli  
VenueCheeseDeli  
IfEatenMiddleEast  
DetailsMiddleEast  
RawMilkMiddleEast  
VenueMiddleEast  
IfEatenMexican  
DetailsMexican  
RawMilkMexican  
VenueMexican  
IfEatenFresco  
DetailsFresco  
RawMilkFresco  
VenueFresco  
IfEatenBlanco  
DetailsBlanco  
RawMilkBlanco  
VenueBlanco  
IfEatenCasero  
DetailsCasero  
RawMilkCasero  
VenueCasero  
IfEatenCuajada  
DetailsCuajada  
RawMilkCuajada  
VenueCuajada  
IfEatenAsadero  
DetailsAsadero  
RawMilkAsadero  
VenueAsadero  
IfEatenCotija  
DetailsCotija  
RawMilkCotija  
VenueCotija  
IfEatenPanella  
DetailsPanella  
RawMilkPanella  
VenuePanella  
IfEatenRanchero  
DetailsRanchero  
RawMilkRanchero  
VenueRanchero

IfEatenRequeson  
DetailsRequeson  
RawMilkRequeson  
VenueRequeson  
IfEatenOaxaca  
DetailsOaxaca  
RawMilkOaxaca  
VenueOaxaca  
IfEatenOtherMex  
DetailsOtherMex  
RawMilkOtherMex  
VenueOtherMex  
SpecifyOtherMex  
IfEatenOtherCheese  
DetailsOtherCheese  
RawMilkOtherCheese  
VenueOtherCheese  
SpecifyOtherCheese  
IfEatenRawCheese  
DetailsRawCheese  
RawMilkRawCheese  
VenueRawCheese  
IfEatenCheese  
DetailsCheese  
RawMilkCheese  
VenueCheese  
SpecifyCheese  
BlueOften  
BlueDeli  
BlueGrocery  
BlueOther  
BlueRestaurant  
VenueBlue2  
VenueBlue3  
VenueBlue4  
DetailsBlue2  
DetailsBlue3  
DetailsBlue4  
DeliCounterBlue  
IfEatenBrie\_Old  
Brie\_OldOften  
Brie\_OldDeli  
Brie\_OldGrocery  
Brie\_OldOther  
Brie\_OldRestaurant  
VenueBrie\_Old1  
VenueBrie\_Old2

VenueBrie\_Old3  
VenueBrie\_Old4  
DetailsBrie\_Old1  
DetailsBrie\_Old2  
DetailsBrie\_Old3  
DetailsBrie\_Old4  
DeliCounterBrie\_Old  
IfEatenCamembert  
CamembertOften  
CamembertDeli  
CamembertGrocery  
CamembertOther  
CamembertRestaurant  
VenueCamembert1  
VenueCamembert2  
VenueCamembert3  
VenueCamembert4  
DetailsCamembert1  
DetailsCamembert2  
DetailsCamembert3  
DetailsCamembert4  
DeliCounterCamembert  
IfEatenFarmers  
FarmersOften  
FarmersDeli  
FarmersGrocery  
FarmersOther  
FarmersRestaurant  
VenueFarmers1  
VenueFarmers2  
VenueFarmers3  
VenueFarmers4  
DetailsFarmers1  
DetailsFarmers2  
DetailsFarmers3  
DetailsFarmers4  
DeliCounterFarmers  
FetaOften  
FetaDeli  
FetaGrocery  
FetaOther  
FetaRestaurant  
VenueFeta2  
VenueFeta3  
VenueFeta4  
DetailsFeta2  
DetailsFeta3

DetailsFeta4  
DeliCounterFeta  
GoatOften  
GoatDeli  
GoatGrocery  
GoatOther  
GoatRestaurant  
VenueGoat2  
VenueGoat3  
VenueGoat4  
DetailsGoat2  
DetailsGoat3  
DetailsGoat4  
DeliCounterGoat  
MexicanOften  
MexicanDeli  
MexicanGrocery  
MexicanOther  
MexicanRestaurant  
VenueMexican2  
VenueMexican3  
VenueMexican4  
DetailsMexican2  
DetailsMexican3  
DetailsMexican4  
DeliCounterMexican  
OtherCheeseOften  
OtherCheeseDeli  
OtherCheeseGrocery  
OtherCheeseOther  
OtherCheeseRestaurant  
VenueOtherCheese2  
VenueOtherCheese3  
VenueOtherCheese4  
DetailsOtherCheese2  
DetailsOtherCheese3  
DetailsOtherCheese4  
DeliCounterOtherCheese  
RawCheeseOften  
RawCheeseDeli  
RawCheeseGrocery  
RawCheeseOther  
RawCheeseRestaurant  
VenueRawCheese2  
VenueRawCheese3  
VenueRawCheese4  
DetailsRawCheese2

DetailsRawCheese3  
DetailsRawCheese4  
DeliCounterRawCheese  
IfEatenMilk  
DetailsMilk  
VenueMilk  
RawUnpasteurizedMilk  
IfEatenWholeMilk  
DetailsWholeMilk  
VenueWholeMilk  
IfEaten2Milk  
Details2Milk  
Venue2Milk  
IfEaten1Milk  
Details1Milk  
Venue1Milk  
IfEatenSkimMilk  
DetailsSkimMilk  
VenueSkimMilk  
IfEatenOtherMilk  
DetailsOtherMilk  
VenueOtherMilk  
SpecifyOtherMilk  
IfEatenNonDairyMilk  
DetailsNonDairyMilk  
VenueNonDairyMilk  
SpecifyNonDairyMilk  
IfEatenFrozenYogurt  
DetailsFrozenYogurt  
VenueFrozenYogurt  
IfEatenYogurt  
RawUnpasteurizedYogurt  
SpecifyYogurt  
DetailsYogurt  
VenueYogurt  
IfEatenYogurtDrink  
DetailsYogurtDrink  
VenueYogurtDrink  
IfEatenButter  
DetailsButter  
VenueButter  
IfEatenCream  
DetailsCream  
VenueCream  
IfEatenIceCreamBars  
DetailsIceCreamBars  
VenueIceCreamBars

IfEatenIceCream  
DetailsIceCream  
VenueIceCream  
SoftServelceCream  
IfEatenSourCream  
DetailsSourCream  
VenueSourCream  
IfEatenShrimp  
DetailsShrimp  
VenueShrimp  
IfEatenShellfish  
SpecifyShellfish  
DetailsShellfish  
VenueShellfish  
IfEatenFish  
DetailsFish  
VenueFish  
IfEatenRawFish  
DetailsRawFish  
VenueRawFish  
IfEatenSeafood  
DetailsSeafood  
VenueSeafood  
IfEatenHummus  
DetailsHummus  
VenueHummus  
IfEatenSalsa  
DetailsSalsa  
VenueSalsa  
IfEatenGuacamole  
DetailsGuacamole  
VenueGuacamole  
IfEatenDip  
DetailsDip  
VenueDip  
SpecifyDip  
HummusOften  
HummusDeli  
HummusGrocery  
HummusOther  
HummusRestaurant  
VenueHummus2  
VenueHummus3  
VenueHummus4  
DetailsHummus2  
DetailsHummus3  
DetailsHummus4

DeliCounterHummus  
IfEatenCrab  
CrabOften  
CrabDeli  
CrabGrocery  
CrabOther  
CrabRestaurant  
VenueCrab  
VenueCrab2  
VenueCrab3  
VenueCrab4  
DetailsCrab  
DetailsCrab2  
DetailsCrab3  
DetailsCrab4  
DeliCounterCrab  
ShrimpOften  
ShrimpDeli  
ShrimpGrocery  
ShrimpOther  
ShrimpRestaurant  
VenueShrimp2  
VenueShrimp3  
VenueShrimp4  
DetailsShrimp2  
DetailsShrimp3  
DetailsShrimp4  
DeliCounterShrimp  
FishOften  
FishDeli  
FishGrocery  
FishOther  
FishRestaurant  
VenueFish2  
VenueFish3  
VenueFish4  
DetailsFish2  
DetailsFish3  
DetailsFish4  
DeliCounterFish  
WholeMilkOften  
WholeMilkDeli  
WholeMilkGrocery  
WholeMilkOther  
WholeMilkRestaurant  
VenueWholeMilk2  
VenueWholeMilk3

VenueWholeMilk4  
DetailsWholeMilk2  
DetailsWholeMilk3  
DetailsWholeMilk4  
RawUnpasteurizedWholeMilk  
\_2MilkOften  
\_2MilkDeli  
\_2MilkGrocery  
\_2MilkOther  
\_2MilkRestaurant  
Venue2Milk2  
Venue2Milk3  
Venue2Milk4  
Details2Milk2  
Details2Milk3  
Details2Milk4  
RawUnpasteurized2Milk  
\_1MilkOften  
\_1MilkDeli  
\_1MilkGrocery  
\_1MilkOther  
\_1MilkRestaurant  
Venue1Milk2  
Venue1Milk3  
Venue1Milk4  
Details1Milk2  
Details1Milk3  
Details1Milk4  
RawUnpasteurized1Milk  
SkimMilkOften  
SkimMilkDeli  
SkimMilkGrocery  
SkimMilkOther  
SkimMilkRestaurant  
VenueSkimMilk2  
VenueSkimMilk3  
VenueSkimMilk4  
DetailsSkimMilk2  
DetailsSkimMilk3  
DetailsSkimMilk4  
RawUnpasteurizedSkimMilk  
OtherMilkOften  
OtherMilkDeli  
OtherMilkGrocery  
OtherMilkOther  
OtherMilkRestaurant  
VenueOtherMilk2

VenueOtherMilk3  
VenueOtherMilk4  
DetailsOtherMilk2  
DetailsOtherMilk3  
DetailsOtherMilk4  
RawUnpasteurizedOtherMilk  
ButterOften  
ButterDeli  
ButterGrocery  
ButterOther  
ButterRestaurant  
VenueButter2  
VenueButter3  
VenueButter4  
DetailsButter2  
DetailsButter3  
DetailsButter4  
CreamOften  
CreamDeli  
CreamGrocery  
CreamOther  
CreamRestaurant  
VenueCream2  
VenueCream3  
VenueCream4  
DetailsCream2  
DetailsCream3  
DetailsCream4  
IceCreamOften  
IceCreamDeli  
IceCreamGrocery  
IceCreamOther  
IceCreamRestaurant  
VenueIceCream2  
VenueIceCream3  
VenueIceCream4  
DetailsIceCream2  
DetailsIceCream3  
DetailsIceCream4  
SourCreamOften  
SourCreamDeli  
SourCreamGrocery  
SourCreamOther  
SourCreamRestaurant  
VenueSourCream2  
VenueSourCream3  
VenueSourCream4

DetailsSourCream2  
DetailsSourCream3  
DetailsSourCream4  
YogurtOften  
YogurtDeli  
YogurtGrocery  
YogurtOther  
YogurtRestaurant  
VenueYogurt2  
VenueYogurt3  
VenueYogurt4  
DetailsYogurt2  
DetailsYogurt3  
DetailsYogurt4  
IfEatenPotato  
DeliCounterPotato  
DetailsPotato  
VenuePotato  
IfEatenPasta  
DeliCounterPasta  
DetailsPasta  
VenuePasta  
IfEatenEgg  
DeliCounterEgg  
DetailsEgg  
VenueEgg  
IfEatenTuna  
DeliCounterTuna  
DetailsTuna  
VenueTuna  
IfEatenChickenSalad  
DeliCounterChickenSalad  
DetailsChickenSalad  
VenueChickenSalad  
IfEatenBeanSalad  
DeliCounterBeanSalad  
DetailsBeanSalad  
VenueBeanSalad  
IfEatenSeafoodSalad  
DeliCounterSeafoodSalad  
DetailsSeafoodSalad  
VenueSeafoodSalad  
IfEatenColeSlaw  
DeliCounterColeSlaw  
DetailsColeSlaw  
VenueColeSlaw  
IfEatenOtherRTESalad

DeliCounterOtherRTESalad  
DetailsOtherRTESalad  
VenueOtherRTESalad  
IfEatenSaladBar  
DetailsSaladBar  
VenueSaladBar  
IfEatenSmoothie  
DetailsSmoothie  
VenueSmoothie  
IfEatenTahini  
DetailsTahini  
VenueTahini  
IfEatenTofu  
DetailsTofu  
VenueTofu  
IfEatenRiceNoodle  
DetailsRiceNoodle  
VenueRiceNoodle  
IfEatenSandwich  
DetailsSandwich  
VenueSandwich  
IfEatenNutButter  
DetailsNutButter  
VenueNutButter  
IfEatenNuts  
DetailsNuts  
VenueNuts  
IfEatenSeeds  
DetailsSeeds  
VenueSeeds  
IfEatenOtherCountry  
DetailsOtherCountry  
VenueOtherCountry  
BeanSaladOften  
BeanSaladDeli  
BeanSaladGrocery  
BeanSaladOther  
BeanSaladRestaurant  
VenueBeanSalad2  
VenueBeanSalad3  
VenueBeanSalad4  
DetailsBeanSalad2  
DetailsBeanSalad3  
DetailsBeanSalad4  
ColeSlawOften  
ColeSlawDeli  
ColeSlawGrocery

ColeSlawOther  
ColeSlawRestaurant  
VenueColeSlaw2  
VenueColeSlaw3  
VenueColeSlaw4  
DetailsColeSlaw2  
DetailsColeSlaw3  
DetailsColeSlaw4  
OtherRTESaladSpecify  
OtherRTESaladOften  
OtherRTESaladDeli  
OtherRTESaladGrocery  
OtherRTESaladOther  
OtherRTESaladRestaurant  
VenueOtherRTESalad2  
VenueOtherRTESalad3  
VenueOtherRTESalad4  
DetailsOtherRTESalad2  
DetailsOtherRTESalad3  
DetailsOtherRTESalad4  
PastaOften  
PastaDeli  
PastaGrocery  
PastaOther  
PastaRestaurant  
VenuePasta2  
VenuePasta3  
VenuePasta4  
DetailsPasta2  
DetailsPasta3  
DetailsPasta4  
PotatoOften  
PotatoDeli  
PotatoGrocery  
PotatoOther  
PotatoRestaurant  
VenuePotato2  
VenuePotato3  
VenuePotato4  
DetailsPotato2  
DetailsPotato3  
DetailsPotato4  
SeafoodSaladOften  
SeafoodSaladDeli  
SeafoodSaladGrocery  
SeafoodSaladOther  
SeafoodSaladRestaurant

VenueSeafoodSalad2  
VenueSeafoodSalad3  
VenueSeafoodSalad4  
DetailsSeafoodSalad2  
DetailsSeafoodSalad3  
DetailsSeafoodSalad4  
TunaOften  
TunaDeli  
TunaGrocery  
TunaOther  
TunaRestaurant  
VenueTuna2  
VenueTuna3  
VenueTuna4  
DetailsTuna2  
DetailsTuna3  
DetailsTuna4  
IfEatenApples  
FruitStateApple  
PreSlicedApple  
VenueApple  
DetailsApple  
IfEatenCarApple  
DetailsCarApple  
VenueCarApple  
IfEatenGrape  
DetailsGrape  
VenueGrape  
IfEatenRaisin  
DetailsRaisin  
VenueRaisin  
IfEatenPear  
FruitStatePear  
DetailsPear  
VenuePear  
IfEatenPeach  
DetailsPeach  
FruitStatePeach  
VenuePeach  
IfEatenNectarine  
FruitStateNectarine  
DetailsNectarine  
VenueNectarine  
IfEatenApricot  
FruitStateApricot  
DetailsApricot  
VenueApricot

IfEatenPlum  
DetailsPlum  
FruitStatePlum  
VenuePlum  
IfEatenStrawberry  
DetailsStrawberry  
FruitStateStrawberry  
VenueStrawberry  
IfEatenRaspberry  
DetailsRaspberry  
FruitStateRaspberry  
VenueRaspberry  
IfEatenBlueberry  
FruitStateBlueberry  
DetailsBlueberry  
VenueBlueberry  
IfEatenBlackberry  
FruitStateBlackberry  
DetailsBlackberry  
VenueBlackberry  
IfEatenCherry  
FruitStateCherry  
DetailsCherry  
VenueCherry  
IfEatenHoneydew  
DetailsHoneydew  
PreSlicedHoneydew  
VenueHoneydew  
IfEatenCantaloupe  
PreSlicedCantaloupe  
DetailsCantaloupe  
VenueCantaloupe  
IfEatenWatermelon  
PreSlicedWatermelon  
DetailsWatermelon  
VenueWatermelon  
IfEatenPineapple  
PreSlicedPineapple  
DetailsPineapple  
VenuePineapple  
IfEatenMango  
PreSlicedMango  
FruitStateMango  
DetailsMango  
VenueMango  
IfEatenPapaya  
FruitStatePapaya

DetailsPapaya  
VenuePapaya  
IfEatenAvocado  
DetailsAvocado  
VenueAvocado  
FruitStateAvocado  
IfEatenFruitSalad  
DetailsFruitSalad  
VenueFruitSalad  
IfEatenOtherFruit  
SpecifyOtherFruit  
FruitStateOtherFruit  
DetailsOtherFruit  
VenueOtherFruit  
IfEatenSorbet  
DetailsSorbet  
VenueSorbet  
IfEatenZoo  
DetailsZoo  
VenueZoo  
IfEatenPetFood  
DetailsPetFood  
VenuePetFood  
IfEatenPetTreats  
DetailsPetTreats  
VenuePetTreats  
FruitSaladOften  
FruitSaladDeli  
FruitSaladGrocery  
FruitSaladOther  
FruitSaladRestaurant  
VenueFruitSalad2  
VenueFruitSalad3  
VenueFruitSalad4  
DetailsFruitSalad2  
DetailsFruitSalad3  
DetailsFruitSalad4  
DeliCounterFruitSalad  
CantaloupeOften  
CantaloupeDeli  
CantaloupeGrocery  
CantaloupeOther  
CantaloupeRestaurant  
VenueCantaloupe2  
VenueCantaloupe3  
VenueCantaloupe4  
DetailsCantaloupe2

DetailsCantaloupe3  
DetailsCantaloupe4  
HoneydewOften  
HoneydewDeli  
HoneydewGrocery  
HoneydewOther  
HoneydewRestaurant  
VenueHoneydew2  
VenueHoneydew3  
VenueHoneydew4  
DetailsHoneydew2  
DetailsHoneydew3  
DetailsHoneydew4  
WatermelonOften  
WatermelonDeli  
WatermelonGrocery  
WatermelonOther  
WatermelonRestaurant  
VenueWatermelon2  
VenueWatermelon3  
VenueWatermelon4  
DetailsWatermelon2  
DetailsWatermelon3  
DetailsWatermelon4  
CaseStatusAPMother  
CaseStatusAPNeonate  
CaseStatusNP  
LabCriteria  
APNeonateAgeAtCollection  
ResultCulture  
ResultCIDT  
EpiLink  
PrInfantOutcomeDeathDate

LocalRecordIDMother

LocalRecordIDNeonate

## Description

ID assigned by database

ID assigned by CDC

Status of report

Version of form

The FoodNet ID for the imported report (if applicable)

The State Epi ID to identify the report being imported.

The Local Epi ID to identify the report being imported.

The name of the interviewer.

Was the isolate sent to the public health laboratory?

If isolate not sent to state lab, why not and could it still be obtained?

The date that the form was completed on.

Gender

The city of residence where the report/case originated.

The county of residence where the report/case originated.

The state of residence where the report/case originated.

Age of case-patient.

Date of birth

Is the case-patient of Hispanic, Latino, or Spanish origin?

Mexican, Mexican American, Chicano

Puerto Rican

Cuban

Another Hispanic, Latino, or Spanish Origin

If another Hispanic, Latino, or Spanish origin, specify.

Unknown Hispanic ancestry/declined to specify

African American/Black

Asian

Asian Indian

Chinese

Filipino

Japanese

Korean

Vietnamese

Other Asian

Other Asian, specify

Native Hawaiian or Other Pacific Islander

Native Hawaiian

Guamanian or Chamorro

Samoan

Other Pacific Islander

Native American or Alaska Native

White

Middle Eastern/North African

Not Middle Eastern/North African

Unknown Race

Other Race

Other Race Specify

Declined to answer race question(s)

Is Listeria case associate with pregnancy?

Not Pregnant: Type of specimen that grew Listeria. - Blood

Not Pregnant: Specimen collection date. - Blood

Not Pregnant: State public health lab isolate ID #. - Blood

Not Pregnant: Type of specimen that grew Listeria. - CSF

Not Pregnant: Specimen collection date. - CSF

Not Pregnant: State public health lab isolate ID #. - CSF

Not Pregnant: Type of specimen that grew Listeria. - Other

Not Pregnant: Specify other type of specimen that grew Listeria.

Not Pregnant: Specimen collection date. - Other

Not Pregnant: State public health lab isolate ID #. - Other

Not Pregnant: Type of specimen that grew Listeria. - Other

Not Pregnant: Specify other type of specimen that grew Listeria.

Not Pregnant: Specimen collection date. - Other

Not Pregnant: State public health lab isolate ID #. - Other

Not Pregnant: Other flag

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Type of illness-Febrile gastroenteritis, non-pregnant case

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Did patient have any types of illnesses related to the Listeria infection? - I

Not Pregnant: Was patient hospitalized for listeriosis?

Not Pregnant: If patient hospitalized for listeriosis, admit date.

Not Pregnant: If patient hospitalized for listeriosis, discharge date.

Not Pregnant: If patient hospitalized for listeriosis, still hospitalized?

Not Pregnant: If patient hospitalized for listeriosis, still hospitalized last date.

Not Pregnant: Did the patient survive?

Not Pregnant: If the patient died, what was the date?

Not Pregnant: If died, was listeriosis or Listeria infection listed on death certificate?

Not Pregnant: If survived, last known date alive.

Pregnant: Type of specimen that grew Listeria. - Blood from mother

Pregnant: Specimen collection date. -Blood from mother

Pregnant: State public health lab isolate ID #. - Blood from mother

Pregnant: Type of specimen that grew Listeria. - Blood from neonate

Pregnant: Specimen collection date. - Blood from neonate

Pregnant: State public health lab isolate ID #. - Blood from neonate

Pregnant: Type of specimen that grew Listeria. - CSF from mother  
Pregnant: Specimen collection date. - CSF from mother  
Pregnant: State public health lab isolate ID #. - CSF from mother  
Pregnant: Type of specimen that grew Listeria. - CSF from neonate  
Pregnant: Specimen collection date. - CSF from neonate  
Pregnant: State public health lab isolate ID #. - CSF from neonate  
Pregnant: Type of specimen that grew Listeria. - Placenta  
Pregnant: Specimen collection date. - Placenta  
Pregnant: State public health lab isolate ID #. - Placenta  
Pregnant: Type of specimen that grew Listeria. - Amniotic Fluid  
Pregnant: Specimen collection date. - Amniotic fluid  
Pregnant: State public health lab isolate ID #. - Amniotic fluid  
Pregnant: Type of specimen that grew Listeria. -Fetal tissue  
Pregnant: Specimen collection date. - Fetal tissue  
Pregnant: State public health lab isolate ID #. - Fetal tissue  
Pregnant: Type of specimen that grew Listeria. - Other  
Pregnant: Specify other type of specimen that grew Listeria. - Other  
Pregnant: Specimen collection date. - Other  
Pregnant: State public health lab isolate ID #. - Other  
Pregnant: Type of specimen that grew Listeria. - Other  
Pregnant: Specify other type of specimen that grew Listeria. - Other  
Pregnant: Specimen collection date. -Other  
Pregnant: State public health lab isolate ID #. - Other  
Pregnant: Other flag

If born outside of the US, specify where.

Denotes that the <case> was born inside the United States.

Denotes that the <case> was born outside the United States.

Primary language of the <case>, either english, spanish, other (specify) or unknown.

Specify the primary language if it is not available in the original list.

If born outside of the US, specify the year <case> arrived.

CDC EFORS ID

Lab submitting blood specimen, non-pregnant case

Lab submitting CSF specimen, non-pregnant case

Lab submitting other specimen 2, non-pregnant case

Lab submitting other specimen, non-pregnant case

Stool specimen grew Listeria, non-pregnant case

Date stool specimen collected, non-pregnant case

Lab submitting stool specimen, non-pregnant case

State public health isolate ID number, stool, non-pregnant case

Lab submitting blood specimen from mother, pregnancy-associated case

Lab submitting blood specimen from neonate, pregnancy-associated case

Lab submitting CSF specimen from mother, pregnancy-associated case

Lab submitting CSF specimen from neonate, pregnancy-associated case

Stool specimen from mother grew Listeria, pregnancy-associated case

Date stool specimen from mother collected, pregnancy-associated case

Lab submitting stool specimen from mother, pregnancy-associated case

State public health isolate ID number, stool specimen from mother, pregnancy-associated case

Lab submitting placenta specimen, pregnancy-associated case  
Lab submitting amniotic fluid specimen, pregnancy-associated case  
Lab submitting other specimen, pregnancy-associated case  
Underlying conditions and treatments. - None  
Underlying conditions and treatments. - Cancer  
If Cancer, Leukemia  
If Cancer, Lymphoma  
If Lymphoma, Hodgkins  
If Lymphoma, Non-Hodgkins  
If Cancer, Multiple Myeloma  
If Cancer, Myeloproliferative disorder  
If Cancer, Other cancer  
If Other Cancer, specify other cancer  
Underlying conditions and treatments. - Kidney dialysis  
Underlying conditions and treatments. - Cirrhosis/advanced liver disease  
Underlying conditions and treatments. - Chronic Obstructive Pulmonary Disease  
Underlying conditions and treatments. - Heart Disease  
If Heart Disease, specify heart disease  
Underlying conditions and treatments. - Organ transplant  
If Organ Transplant, specify organ  
Underlying conditions and treatments. - Unknown  
Underlying conditions and treatments. - Other conditions  
Underlying conditions and treatments. - Crohn's  
Underlying conditions and treatments. - Diabetes mellitus  
If Diabetes mellitus, Type 1  
If Diabetes mellitus, Type 2  
Underlying conditions and treatments. - Giant cell arteritis  
Underlying conditions and treatments. - Hemochromatosis/iron overload  
Underlying conditions and treatments. - HIV/AIDS  
If HIV/AIDS, HIV (no AIDS)  
If HIV/AIDS, AIDS  
Underlying conditions and treatments. - Lupus  
Underlying conditions and treatments. - Rheumatoid arthritis  
Underlying conditions and treatments. - Sarcoidosis  
Underlying conditions and treatments. - Sickle cell disease  
Underlying conditions and treatments. - Splenectomy/asplenia  
Underlying conditions and treatments. - Ulcerative colitis  
Underlying conditions and treatments. - Other condition  
If Other Condition, specify other conditions  
Underlying conditions and treatments. - Pregnancy  
Underlying conditions and treatments. - Immunosuppressive medication  
If Immunosuppressive medication, Corticosteroids/steroids  
If Immunosuppressive medication, Cancer chemotherapy  
If Immunosuppressive medication, Other immunosuppressive therapy  
If Other Immunosuppressive therapy, specify therapy  
Underlying conditions and treatments. - Excessive alcohol use  
Underlying conditions and treatments. - Injection drug user

Underlying conditions and treatments. - Medications that suppress stomach acid

If Medications that suppress stomach acid, specify medications

Was patient or surrogate able to be interviewed?

If patient or surrogate was not interviewed, why not?

Other reason patient or surrogate was not interviewed.

StomachUlcers

Arthritis

KidneyDisease

StomachSurgery

Hypertension

ESRD

ChronicDiarrhea

Comments

Underlying

Radiation

Antibiotics

Other symptoms

Name of store/restaurant/other venue where soft white cheese purchased 3

Name of store/restaurant/other venue where soft white cheese purchased 4

Name of store/restaurant/other venue where soft white cheese purchased 5

Other 2 specify

Other 3 specify

Other 4 specify

Other 5 specify

Pregnant: Infant 1 pregnancy outcome.

Pregnant: Infant 1 weeks of gestation.

Pregnant: Infant 1 delivery type.

Pregnant: Infant 1 pregnancy outcome date.

Pregnant: Specify other outcome of pregnancy for infant 1?

Pregnant: Infant 1 pregnancy outcome.

Pregnant: Infant 1 weeks of gestation.

Pregnant: Infant 1 delivery type.

Pregnant: Infant 1 pregnancy outcome date.

Pregnant: Specify other outcome of pregnancy for infant 1?

Pregnant: Type(s) of illness in mother.-Fever

Pregnant: Type(s) of illness in mother.-Bacteremia/sepsis

Pregnant: Type(s) of illness in mother.-Meningitis

Pregnant: Type(s) of illness in mother.-Amnionitis

Pregnant: Type(s) of illness in mother.-Non-specific flu-like illness

Pregnant: Type(s) of illness in mother.-None

Pregnant: Type(s) of illness in mother.-Other

Pregnant: If Other Illness, specify

Pregnant: Type(s) of illness in mother.-Unknown

Pregnant: Was mother hospitalized for listeriosis?

Pregnant: If mother was hospitalized for listeriosis, admit date.

Pregnant: If mother was hospitalized for listeriosis, discharge date.

Pregnant: If mother was hospitalized for listeriosis, still hospitalized?

Pregnant: If mother was hospitalized for listeriosis, name of hospital.

Pregnant: Did the mother survive?

Pregnant: If the mother survived, last known date alive.

Pregnant: If the mother died, was listeriosis or Listeria infection listed on death certificate?

Pregnant: Type(s) of illness in infant 1.-Bacteremia/sepsis

Pregnant: Type(s) of illness in infant 1.-Meningitis

Pregnant: Type(s) of illness in infant 1.-Pneumonia

Pregnant: Type(s) of illness in infant 1.-None

Pregnant: Type(s) of illness in infant 1.-Other

Pregnant: Specify other type(s) of illness in infant 1.

Pregnant: Type(s) of illness in infant 1.-Unknown

Pregnant: Where was infant 1 delivered?

Pregnant: If infant 1 was delivered at a hospital, admit date.

Pregnant: If infant 1 was delivered at a hospital, discharge date.

Pregnant: If infant 1 was delivered at a hospital, still hospitalized?

Pregnant: If infant 1 was hospitalized for listeriosis, name of hospital.

Pregnant: Specify other location where infant 1 was delivered?

Pregnant: Was infant 1 hospitalized for listeriosis?

Pregnant: If infant 1 was hospitalized for listeriosis, admit date.

Pregnant: If infant 1 was hospitalized for listeriosis, discharge date.

Pregnant: If infant 1 was hospitalized for listeriosis, still hospitalized?

Pregnant: Did infant 1 survive?

Pregnant: If infant 1 survived, last known date alive.

Pregnant: If infant 1 died, was listeriosis or Listeria infection listed on death certificate?

Pregnant: Type(s) of illness in infant 2.-Bacteremia/sepsis

Pregnant: Type(s) of illness in infant 2.-Meningitis

Pregnant: Type(s) of illness in infant 2.-Pneumonia

Pregnant: Type(s) of illness in infant 2.-None

Pregnant: Type(s) of illness in infant 2.-Other

Pregnant: Specify other type(s) of illness in infant 2.

Pregnant: Type(s) of illness in infant 2.-Unknown

Pregnant: Where was infant 2 delivered?

Pregnant: If infant 2 was delivered at a hospital, admit date.

Pregnant: If infant 2 was delivered at a hospital, discharge date.

Pregnant: If infant 2 was delivered at a hospital, still hospitalized?

Pregnant: If infant 2 was hospitalized for listeriosis, name of hospital.

Pregnant: Specify other location where infant 2 was delivered?

Pregnant: Was infant 2 hospitalized for listeriosis?

Pregnant: If infant 2 was hospitalized for listeriosis, admit date.

Pregnant: If infant 2 was hospitalized for listeriosis, discharge date.

Pregnant: If infant 2 was hospitalized for listeriosis, still hospitalized?

Pregnant: Did infant 2 survive?

Pregnant: If infant 2 survived, last known date alive.

Pregnant: If infant 2 died, was listeriosis or Listeria infection listed on death certificate?

Pregnant: Type(s) of illness in mother.-Gastroenteritis

Pregnant: Type(s) of illness in infant1.-Granulomatosis

Pregnant: Type(s) of illness in infant2.-Granulomatosis

Date of patient interview.

Respondent of the patient interview.

If respondent was surrogate, relationship to patient.

If respondent was surrogate, relationship to patient specify other.

Date illness began.

Date illness began does not apply.

During the 4 weeks before illness/delivery date, was admitted to a hospital?

If admitted to a hospital, admission date.

If admitted to a hospital, discharge date.

If admitted to a hospital, hospital name.

If admitted to a hospital, still residing there?

During the 4 weeks before illness/delivery date, was admitted to a nursing home?

Date admitted to nursing home (if resident in 4 weeks prior to onset)

Discharge date from nursing home (if resident in 4 weeks prior to onset)

If admitted to a nursing home, still residing there?

If admitted to a nursing home, nursing home name.

Did travel outside state of residence?

If traveled outside state of residence, names of states.

Did travel outside state of the U.S.?

If traveled outside U.S., names of countries.

If traveled outside U.S., departure date.

If traveled outside U.S., return date.

Patient symptom name associated with illness.-Fever

Patient symptom name associated with illness.-Chills

Patient symptom name associated with illness.-Diarrhea

Patient symptom name associated with illness.-Vomiting

Patient symptom name associated with illness.-Preterm labor

Patient symptom name associated with illness.-Muscle Aches

Patient symptom name associated with illness.-Headache

Patient symptom name associated with illness.-Stiff neck

Patient symptom name associated with illness.-Altered mental status

Patient symptom name associated with illness.-Other

Specify other patient symptom.

Patient symptom name associated with illness.-Other

Specify other patient symptom.

Other symptom flag

Illness/delivery date

4-week start date

4-week end date

Whether or not <case> had allergies that prevented <case> from eating certain foods.

The name of the food that <case> has allergies toward.-Milk

The name of the food that <case> has allergies toward.-Eggs

The name of the food that <case> has allergies toward.-Peanuts

The name of the food that <case> has allergies toward.-Tree Nuts

The name of the food that <case> has allergies toward.-Fish

The name of the food that <case> has allergies toward.-Soy

The name of the food that <case> has allergies toward.-Wheat

The name of the food that <case> has allergies toward.-Shellfish  
The name of the food that <case> has allergies toward.-Other  
If Other (specify) was the given allergy, then specify allergy here.  
Whether or not <case> had a vegetarian or vegan diet.

If yes to vegetarian or vegan diet, this denotes a vegetarian diet.

If yes to vegetarian or vegan diet, this denotes a vegan diet.

Whether or not <case> had a restricted diet.

A description of the restricted diet that <case> was on.

The name of the store from which the food was acquired

The location of the store from which the food was acquired.

The name of the store from which the food was acquired

The location of the store from which the food was acquired.

The name of the store from which the food was acquired

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The name of the store from which the food was acquired

The location of the store from which the food was acquired.

The name of the store from which the food was acquired

The location of the store from which the food was acquired.

Grocery store flag

Whether or not <case> agreed to release shopper card information.

The name of the store associated with the shopper card information.

The number and/or characters that uniquely identify the shopper card.

The name of the store associated with the shopper card information.

The number and/or characters that uniquely identify the shopper card.

The name of the store associated with the shopper card information.

The number and/or characters that uniquely identify the shopper card.

Shopper card name flag

The name of the restaurant where <case> may have eaten.

The location of the restaurant where <case> may have eaten.

The food that <case> may have eaten at the restaurant.

Restaurant 1 date 1

Restaurant 1 date 2

Restaurant 1 date 3

Restaurant 1 date 4

Restaurant 1 date 5

The name of the restaurant where <case> may have eaten.

The location of the restaurant where <case> may have eaten.

The food that <case> may have eaten at the restaurant.

Restaurant 2 date 1

Restaurant 2 date 2

Restaurant 2 date 3

Restaurant 2 date 4

Restaurant 2 date 5

The name of the restaurant where <case> may have eaten.

The location of the restaurant where <case> may have eaten.

The food that <case> may have eaten at the restaurant.

Restaurant 3 date 1

Restaurant 3 date 2

Restaurant 3 date 3

Restaurant 3 date 4

Restaurant 3 date 5

The name of the restaurant where <case> may have eaten.

The location of the restaurant where <case> may have eaten.

The food that <case> may have eaten at the restaurant.

Restaurant 4 date 1

Restaurant 4 date 2

Restaurant 4 date 3

Restaurant 4 date 4

Restaurant 4 date 5

The name of the restaurant where <case> may have eaten.

The location of the restaurant where <case> may have eaten.

The food that <case> may have eaten at the restaurant.

Restaurant 5 date 1

Restaurant 5 date 2

Restaurant 5 date 3

Restaurant 5 date 4

Restaurant 5 date 5

The name of the restaurant where <case> may have eaten.

The location of the restaurant where <case> may have eaten.

The food that <case> may have eaten at the restaurant.

Restaurant 6 date 1

Restaurant 6 date 2

Restaurant 6 date 3

Restaurant 6 date 4

Restaurant 6 date 5

The name of the restaurant where <case> may have eaten.

The location of the restaurant where <case> may have eaten.

The food that <case> may have eaten at the restaurant.

Restaurant 7 date 1

Restaurant 7 date 2

Restaurant 7 date 3

Restaurant 7 date 4

Restaurant 7 date 5

Reastaurant flag

The name of the other location where <case> may have eaten.

The location of the other location where <case> may have eaten.

The food that <case> may have eaten at the other location.

Other venue 1 date 1

Other venue 1 date 2

Other venue 1 date 3

Other venue 1 date 4

Other venue 1 date 5

The name of the other location where <case> may have eaten.

The location of the other location where <case> may have eaten.

The food that <case> may have eaten at the other location.

Other venue 2 date 1

Other venue 2 date 2

Other venue 2 date 3

Other venue 2 date 4

Other venue 2 date 5

The name of the other location where <case> may have eaten.

The location of the other location where <case> may have eaten.

The food that <case> may have eaten at the other location.

Other venue 3 date 1

Other venue 3 date 2

Other venue 3 date 3

Other venue 3 date 4

Other venue 3 date 5

The name of the other location where <case> may have eaten.

The location of the other location where <case> may have eaten.

The food that <case> may have eaten at the other location.

Other venue 4 date 1

Other venue 4 date 2

Other venue 4 date 3

Other venue 4 date 4

Other venue 4 date 5

The name of the other location where <case> may have eaten.

The location of the other location where <case> may have eaten.

The food that <case> may have eaten at the other location.

Other venue 5 date 1

Other venue 5 date 2

Other venue 5 date 3

Other venue 5 date 4

Other venue 5 date 5

The name of the other location where <case> may have eaten.

The location of the other location where <case> may have eaten.

The food that <case> may have eaten at the other location.

Other venue 6 date 1

Other venue 6 date 2

Other venue 6 date 3

Other venue 6 date 4

Other venue 6 date 5

The name of the other location where <case> may have eaten.

The location of the other location where <case> may have eaten.

The food that <case> may have eaten at the other location.

Other venue 7 date 1

Other venue 7 date 2

Other venue 7 date 3

Other venue 7 date 4

Other venue 7 date 5

Other venue 7 date 6

Any other food items <case> ate that we didn't talk about already.

Any seasonal foods or special foods <case> ate during the last 4 weeks.

Name of delicatessen, small local market, other small shop, or farmers markets 1

Street address, city, county, state of delicatessen, small local market, other small shop, or farmers markets 1

Name of delicatessen, small local market, other small shop, or farmers markets 2

Street address, city, county, state of delicatessen, small local market, other small shop, or farmers markets 2

Name of delicatessen, small local market, other small shop, or farmers markets 3

Street address, city, county, state of delicatessen, small local market, other small shop, or farmers markets 3

Name of delicatessen, small local market, other small shop, or farmers markets 4

Street address, city, county, state of delicatessen, small local market, other small shop, or farmers markets 4

Name of delicatessen, small local market, other small shop, or farmers markets 5

Street address, city, county, state of delicatessen, small local market, other small shop, or farmers markets 5

Name of delicatessen, small local market, other small shop, or farmers markets 6

Street address, city, county, state of delicatessen, small local market, other small shop, or farmers markets 6

Name of delicatessen, small local market, other small shop, or farmers markets 7

Street address, city, county, state of delicatessen, small local market, other small shop, or farmers markets 7

Did you eat food purchased from any delicatessens, small local markets, other small shops, or farmers markets during the 4 week time period

Did you eat food purchased from any grocery stores during the 4 week time period

Did you eat food purchased or obtained from any other venues, such as school cafeteria, church, or community center during the 4 week time period

Did you eat food from any restaurants, including sit-down, fast-food, and take-out restaurants during the 4 week time period

Initials of interviewer

Interviewer comments on food consumption history

General interviewer comments

Ham

Ham

Ham

Ham

Bologna

Bologna

Bologna

Bologna

Turkey breast

Turkey breast

Turkey breast

Turkey breast

Chicken deli meat

Chicken deli meat

Chicken deli meat

Chicken deli meat

Roast beef

Roast beef

Roast beef

Roast beef

Pastrami  
Pastrami  
Pastrami  
Pastrami  
Liverwurst or braunschweiger  
Liverwurst or braunschweiger  
Liverwurst or braunschweiger  
Liverwurst or braunschweiger  
Pate or meat spread that was not canned  
Pate or meat spread that was not canned  
Pate or meat spread that was not canned  
Head cheese  
Head cheese  
Head cheese  
Head cheese  
Pepperoni  
Pepperoni  
Pepperoni  
Pepperoni  
Any other Italian-style meats  
Any other Italian-style meats  
Any other Italian-style meats  
Any other Italian-style meats  
Other deli/luncheon meat  
Other deli/luncheon meat  
Other deli/luncheon meat  
Other deli/luncheon meat  
Other deli/luncheon meat  
Anything from deli area where meat is sliced  
Anything from deli area where meat is sliced  
Anything from deli area where meat is sliced  
Anything from deli area where meat is sliced  
Anything from deli area where meat is sliced  
Precooked sausage  
Precooked sausage  
Precooked sausage  
Precooked chicken  
Precooked chicken  
Precooked chicken  
Other precooked meat  
Other precooked meat  
Other precooked meat  
Other precooked meat  
Cured or dried meat  
Cured or dried meat  
Cured or dried meat  
Hot dogs

Hot dogs

Was hot dog heated prior to being eaten?

Hot dogs

Frozen processed poultry

Frozen processed poultry

Frozen processed poultry

Frozen processed poultry

Grounch chicken or turkey

Grounch chicken or turkey

Grounch chicken or turkey

Grounch chicken or turkey

If ate bologna, how often?

Was bologna purchased at a deli/small market?

Was bologna purchased at grocery store?

Was bologna purchased at an other venue?

BolognaRestaurant

VenueBologna2

VenueBologna3

VenueBologna4

DetailsBologna2

DetailsBologna3

DetailsBologna4

ChickenOften

ChickenDeli

ChickenGrocery

ChickenOther

ChickenRestaurant

VenueChicken2

VenueChicken3

VenueChicken4

DetailsChicken2

DetailsChicken3

DetailsChicken4

If ate ham, how often?

Was ham purchased at a deli/small market ?

Was ham purchased at a grocery store?

Was ham purchased at an other venue?

HamRestaurant

VenueHam2

VenueHam3

VenueHam4

DetailsHam2

DetailsHam3

DetailsHam4

If at other deli meat, how often?

Was other deli meat purchased at a deli/small market?

Was other deli meat purchased at a grocery store?

Was other deli meat purchased at an other venue?

OtherDeliRestaurant

VenueOtherDeli2

VenueOtherDeli3

VenueOtherDeli4

DetailsOtherDeli2

DetailsOtherDeli3

DetailsOtherDeli4

IfEatenOtherTurkey

OtherTurkeyOften

OtherTurkeyDeli

OtherTurkeyGrocery

OtherTurkeyOther

OtherTurkeyRestaurant

VenueOtherTurkey

VenueOtherTurkey2

VenueOtherTurkey3

VenueOtherTurkey4

DetailsOtherTurkey

DetailsOtherTurkey2

DetailsOtherTurkey3

DetailsOtherTurkey4

DeliSlicedOtherTurkey

If ate pastrami, how often?

Was pastrami purchased at a deli/small market?

Was pastrami purchased at a grocery store?

Was pastrami purchased at an other venue?

PastramiRestaurant

VenuePastrami2

VenuePastrami3

VenuePastrami4

DetailsPastrami2

DetailsPastrami3

DetailsPastrami4

If yes, how often was pate eaten?

Was pate purchased at a deli/small market?

Was pate purchased at a grocery store?

Was pate purchased at an other venue?

PateRestaurant

VenuePate2

VenuePate3

VenuePate4

DetailsPate2

DetailsPate3

DetailsPate4

DeliSlicedPate

TurkeyBreastOften

TurkeyBreastDeli  
TurkeyBreastGrocery  
TurkeyBreastOther  
TurkeyBreastRestaurant

VenueTurkeyBreast2  
VenueTurkeyBreast3  
VenueTurkeyBreast4

DetailsTurkeyBreast2  
DetailsTurkeyBreast3  
DetailsTurkeyBreast4

DeliSlicedHotDog

If yes, how often did you eat hot dogs?

Were hotdogs purchased at a deli/small market?

Were hotdogs purchased at a grocery store?

Were hotdogs purchased at an other venue?

HotDogRestaurant

VenueHotDog2

VenueHotDog3

VenueHotDog4

DetailsHotDog2

DetailsHotDog3

DetailsHotDog4

IfEatenSprouts

DetailsSprouts

VenueSprouts

Sprouts: Bean

Sprouts: Bean

Sprouts: Bean

Sprouts:Alfalfa

Sprouts:Alfalfa

Sprouts:Alfalfa

Sprouts:Clover

Sprouts:Clover

Sprouts:Clover

Sprouts:Radish

Sprouts:Radish

Sprouts:Radish

Sprouts:Broccoli

Sprouts:Broccoli

Sprouts:Broccoli

Sprouts:Mixed

Sprouts:Mixed

Sprouts:Mixed

Sprouts:Other

Sprouts:Other

Sprouts:Other

Sprouts:Other

Cucumber  
Cucumber  
Cucumber  
Pea pods/snap peas/snow peas  
Pea pods/snap peas/snow peas  
Pea pods/snap peas/snow peas  
Sweet peppers  
Sweet peppers  
Sweet peppers  
Hot chili peppers  
Hot chili peppers  
Hot chili peppers  
Green onions or scallions  
Green onions or scallions  
Green onions or scallions  
Celery  
Celery  
Celery  
Mini-carrots  
Mini-carrots  
Mini-carrots  
Fresh mushrooms  
Fresh mushrooms  
Fresh mushrooms  
Pre-cut raw vegetables or vegetabel mixes  
Pre-cut raw vegetables or vegetabel mixes  
Pre-cut raw vegetables or vegetabel mixes  
Pre-cut raw vegetables or vegetabel mixes  
Fresh basil  
Fresh basil  
Fresh basil  
Fresh cilantro  
Fresh cilantro  
Fresh cilantro  
Fresh parsely  
Fresh parsely  
Fresh parsely  
Other fresh herbs  
Other fresh herbs  
Other fresh herbs  
Other fresh herbs  
Fresh tomatoes  
Fresh tomatoes  
Fresh tomatoes  
Tomatoes: Red round  
Tomatoes: Red round  
Tomatoes: Red round

Tomatoes: Roma  
Tomatoes: Roma  
Tomatoes: Roma  
Tomatoes: Cherry/grape  
Tomatoes: Cherry/grape  
Tomatoes: Cherry/grape  
Tomatoes: Vine-ripe, sold on vine  
Tomatoes: Vine-ripe, sold on vine  
Tomatoes: Vine-ripe, sold on vine  
Tomatoes: Other  
Tomatoes: Other  
Tomatoes: Other  
Tomatoes: Other  
Any lettuce  
Was lettuce prepackaged or bagged?  
Specify type and brand of bagged lettuce  
Any lettuce  
Any lettuce  
Lettuce:Iceburg  
Lettuce:Iceburg  
Lettuce:Iceburg  
Lettuce:Romaine  
Lettuce:Romaine  
Lettuce:Romaine  
Lettuce:Mesclun  
Lettuce:Mesclun  
Lettuce:Mesclun  
Lettuce:Radish  
Lettuce:Radish  
Lettuce:Radish  
Lettuce:Any other leaf lettuce  
Lettuce:Any other leaf lettuce  
Lettuce:Any other leaf lettuce  
Lettuce:Any other leaf lettuce  
Other prepackaged leafy green  
Other prepackaged leafy green  
Other prepackaged leafy green  
Other prepackaged leafy green  
Premade green salad  
Premade green salad  
Premade green salad  
Other produce  
Other produce  
Other produce  
Other produce  
SproutsOften  
SproutsDeli

SproutsGrocery  
SproutsOther  
SproutsRestaurant  
VenueSprouts2  
VenueSprouts3  
VenueSprouts4  
DetailsSprouts2  
DetailsSprouts3  
DetailsSprouts4  
DeliCounterSprouts  
If eaten feta  
Details feta  
Raw milk feta  
Venue feta  
If eaten goat  
Details goat  
Raw milk goat  
Venue goat  
If eaten blue  
Details blue  
Raw milk blue  
Venue blue  
If eaten brie  
Details brie  
Raw milk brie  
Venue brie  
If eaten gouda  
Details gouda  
Raw milk gouda  
Gouda  
IfEatenShred  
DetailsShred  
RawMilkShred  
VenueShred  
IfEatenMozz  
DetailsMozz  
RawMilkMozz  
VenueMozz  
IfEatenCottage  
DetailsCottage  
RawMilkCottage  
VenueCottage  
IfEatenRicotta  
DetailsRicotta  
RawMilkRicotta  
VenueRicotta  
DetailsGourmet

IfEatenGourmet  
RawMilkGourmet  
VenueGourmet  
IfEatenCheeseDeli  
DetailsCheeseDeli  
RawMilkCheeseDeli  
VenueCheeseDeli  
IfEatenMiddleEast  
DetailsMiddleEast  
RawMilkMiddleEast  
VenueMiddleEast  
IfEatenMexican  
DetailsMexican  
RawMilkMexican  
VenueMexican  
IfEatenFresco  
DetailsFresco  
RawMilkFresco  
VenueFresco  
IfEatenBlanco  
DetailsBlanco  
RawMilkBlanco  
VenueBlanco  
IfEatenCasero  
DetailsCasero  
RawMilkCasero  
VenueCasero  
IfEatenCuajada  
DetailsCuajada  
RawMilkCuajada  
VenueCuajada  
IfEatenAsadero  
DetailsAsadero  
RawMilkAsadero  
VenueAsadero  
IfEatenCotija  
DetailsCotija  
RawMilkCotija  
VenueCotija  
IfEatenPanella  
DetailsPanella  
RawMilkPanella  
VenuePanella  
IfEatenRanchero  
DetailsRanchero  
RawMilkRanchero  
VenueRanchero

IfEatenRequeson  
DetailsRequeson  
RawMilkRequeson  
VenueRequeson  
IfEatenOaxaca  
DetailsOaxaca  
RawMilkOaxaca  
VenueOaxaca  
IfEatenOtherMex  
DetailsOtherMex  
RawMilkOtherMex  
VenueOtherMex  
SpecifyOtherMex  
IfEatenOtherCheese  
DetailsOtherCheese  
RawMilkOtherCheese  
VenueOtherCheese  
SpecifyOtherCheese  
IfEatenRawCheese  
DetailsRawCheese  
RawMilkRawCheese  
VenueRawCheese  
IfEatenCheese  
DetailsCheese  
RawMilkCheese  
VenueCheese  
SpecifyCheese  
BlueOften  
BlueDeli  
BlueGrocery  
BlueOther  
BlueRestaurant  
VenueBlue2  
VenueBlue3  
VenueBlue4  
DetailsBlue2  
DetailsBlue3  
DetailsBlue4  
DeliCounterBlue  
IfEatenBrie\_Old  
Brie\_OldOften  
Brie\_OldDeli  
Brie\_OldGrocery  
Brie\_OldOther  
Brie\_OldRestaurant  
VenueBrie\_Old1  
VenueBrie\_Old2

VenueBrie\_Old3  
VenueBrie\_Old4  
DetailsBrie\_Old1  
DetailsBrie\_Old2  
DetailsBrie\_Old3  
DetailsBrie\_Old4  
DeliCounterBrie\_Old  
IfEatenCamembert  
CamembertOften  
CamembertDeli  
CamembertGrocery  
CamembertOther  
CamembertRestaurant  
VenueCamembert1  
VenueCamembert2  
VenueCamembert3  
VenueCamembert4  
DetailsCamembert1  
DetailsCamembert2  
DetailsCamembert3  
DetailsCamembert4  
DeliCounterCamembert  
IfEatenFarmers  
FarmersOften  
FarmersDeli  
FarmersGrocery  
FarmersOther  
FarmersRestaurant  
VenueFarmers1  
VenueFarmers2  
VenueFarmers3  
VenueFarmers4  
DetailsFarmers1  
DetailsFarmers2  
DetailsFarmers3  
DetailsFarmers4  
DeliCounterFarmers  
If ate feta, how often?  
Was feta purchased from a deli/small market?  
Was feta purchased from a grocery store?  
Was feta purchased at an other venue?  
FetaRestaurant  
VenueFeta2  
VenueFeta3  
VenueFeta4  
DetailsFeta2  
DetailsFeta3

DetailsFeta4  
DeliCounterFeta  
If ate goat cheese, how often?  
Was goat cheese purchased at a deli?  
Was goat cheese purchased at a grocery store?  
Was goat cheese purchased at an other venue?  
GoatRestaurant  
VenueGoat2  
VenueGoat3  
VenueGoat4  
DetailsGoat2  
DetailsGoat3  
DetailsGoat4  
DeliCounterGoat  
MexicanOften  
MexicanDeli  
MexicanGrocery  
MexicanOther  
MexicanRestaurant  
VenueMexican2  
VenueMexican3  
VenueMexican4  
DetailsMexican2  
DetailsMexican3  
DetailsMexican4  
DeliCounterMexican  
OtherCheeseOften  
OtherCheeseDeli  
OtherCheeseGrocery  
OtherCheeseOther  
OtherCheeseRestaurant  
VenueOtherCheese2  
VenueOtherCheese3  
VenueOtherCheese4  
DetailsOtherCheese2  
DetailsOtherCheese3  
DetailsOtherCheese4  
DeliCounterOtherCheese  
RawCheeseOften  
RawCheeseDeli  
RawCheeseGrocery  
RawCheeseOther  
RawCheeseRestaurant  
VenueRawCheese2  
VenueRawCheese3  
VenueRawCheese4  
DetailsRawCheese2

DetailsRawCheese3  
DetailsRawCheese4  
DeliCounterRawCheese  
IfEatenMilk  
DetailsMilk  
VenueMilk  
RawUnpasteurizedMilk  
IfEatenWholeMilk  
DetailsWholeMilk  
VenueWholeMilk  
IfEaten2Milk  
Details2Milk  
Venue2Milk  
IfEaten1Milk  
Details1Milk  
Venue1Milk  
IfEatenSkimMilk  
DetailsSkimMilk  
VenueSkimMilk  
IfEatenOtherMilk  
DetailsOtherMilk  
VenueOtherMilk  
SpecifyOtherMilk  
IfEatenNonDairyMilk  
DetailsNonDairyMilk  
VenueNonDairyMilk  
SpecifyNonDairyMilk  
IfEatenFrozenYogurt  
DetailsFrozenYogurt  
VenueFrozenYogurt  
IfEatenYogurt  
RawUnpasteurizedYogurt  
SpecifyYogurt  
DetailsYogurt  
VenueYogurt  
IfEatenYogurtDrink  
DetailsYogurtDrink  
VenueYogurtDrink  
IfEatenButter  
DetailsButter  
VenueButter  
IfEatenCream  
DetailsCream  
VenueCream  
IfEatenIceCreamBars  
DetailsIceCreamBars  
VenueIceCreamBars

IfEatenIceCream

DetailsIceCream

VenueIceCream

Was any ice cream soft serve?

IfEatenSourCream

DetailsSourCream

VenueSourCream

IfEatenShrimp

DetailsShrimp

VenueShrimp

IfEatenShellfish

SpecifyShellfish

DetailsShellfish

VenueShellfish

IfEatenFish

DetailsFish

VenueFish

IfEatenRawFish

DetailsRawFish

VenueRawFish

IfEatenSeafood

DetailsSeafood

VenueSeafood

IfEatenHummus

DetailsHummus

VenueHummus

IfEatenSalsa

DetailsSalsa

VenueSalsa

IfEatenGuacamole

DetailsGuacamole

VenueGuacamole

IfEatenDip

DetailsDip

VenueDip

SpecifyDip

If at hummus, how often?

Was hummus purchased from a deli/small market?

Was hummus purchased from a grocery store?

Was hummus purchased from an other venue?

HummusRestaurant

VenueHummus2

VenueHummus3

VenueHummus4

DetailsHummus2

DetailsHummus3

DetailsHummus4

DeliCounterHummus

IfEatenCrab

If ate precooked crab, how often?

Was crab purchased at a deli/small market?

Was crab purchased at a grocery store?

Was crab purchased at an other venue?

CrabRestaurant

VenueCrab

VenueCrab2

VenueCrab3

VenueCrab4

DetailsCrab

DetailsCrab2

DetailsCrab3

DetailsCrab4

DeliCounterCrab

If ate precooked shrimp, how often?

Was shrimp purchased at a deli/small market?

Was shrimp purchased at a grocery store?

Was shrimp purchased at an other venue?

ShrimpRestaurant

VenueShrimp2

VenueShrimp3

VenueShrimp4

DetailsShrimp2

DetailsShrimp3

DetailsShrimp4

DeliCounterShrimp

FishOften

FishDeli

FishGrocery

FishOther

FishRestaurant

VenueFish2

VenueFish3

VenueFish4

DetailsFish2

DetailsFish3

DetailsFish4

DeliCounterFish

WholeMilkOften

WholeMilkDeli

WholeMilkGrocery

WholeMilkOther

WholeMilkRestaurant

VenueWholeMilk2

VenueWholeMilk3

VenueWholeMilk4  
DetailsWholeMilk2  
DetailsWholeMilk3  
DetailsWholeMilk4  
RawUnpasteurizedWholeMilk  
\_2MilkOften  
\_2MilkDeli  
\_2MilkGrocery  
\_2MilkOther  
\_2MilkRestaurant  
Venue2Milk2  
Venue2Milk3  
Venue2Milk4  
Details2Milk2  
Details2Milk3  
Details2Milk4  
RawUnpasteurized2Milk  
\_1MilkOften  
\_1MilkDeli  
\_1MilkGrocery  
\_1MilkOther  
\_1MilkRestaurant  
Venue1Milk2  
Venue1Milk3  
Venue1Milk4  
Details1Milk2  
Details1Milk3  
Details1Milk4  
RawUnpasteurized1Milk  
If ate skim milk, how often?  
Was skim milk purchased at a deli/small market?  
Was skim milk purchased at a grocery store?  
Was skim milk purchased at an other venue?  
SkimMilkRestaurant  
VenueSkimMilk2  
VenueSkimMilk3  
VenueSkimMilk4  
DetailsSkimMilk2  
DetailsSkimMilk3  
DetailsSkimMilk4  
RawUnpasteurizedSkimMilk  
If ate other milk, how often?  
Was other milk purchased at a deli/small market?  
Was other milk purchased at a grocery store?  
Was other milk purchased at an other venue?  
OtherMilkRestaurant  
VenueOtherMilk2

VenueOtherMilk3

VenueOtherMilk4

DetailsOtherMilk2

DetailsOtherMilk3

DetailsOtherMilk4

RawUnpasteurizedOtherMilk

If ate butter, how often?

Was butter purchased at a deli/small market?

Was butter purchased at a grocery store?

Was butter purchased at an other venue?

ButterRestaurant

VenueButter2

VenueButter3

VenueButter4

DetailsButter2

DetailsButter3

DetailsButter4

If ate cream, how often?

Was cream purchased at a deli/small market?

Was cream purchased at a grocery store?

Was cream purchased at an other venue?

CreamRestaurant

VenueCream2

VenueCream3

VenueCream4

DetailsCream2

DetailsCream3

DetailsCream4

If ate ice cream, how often?

IceCreamDeli

Was ice cream purchased at a grocery store?

Was ice cream purchased at an other venue?

IceCreamRestaurant

VenueIceCream2

VenueIceCream3

VenueIceCream4

DetailsIceCream2

DetailsIceCream3

DetailsIceCream4

If ate sour cream, how often?

Was sour cream purchased at a deli/small market?

Was sour cream purchased at a grocery store?

Was sour cream purchased at an other venue?

SourCreamRestaurant

VenueSourCream2

VenueSourCream3

VenueSourCream4

DetailsSourCream2  
DetailsSourCream3  
DetailsSourCream4  
If ate yogurt, how often?  
Was yogurt purchased at a deli/small market?  
Was yogurt purchased at a grocery store?  
Was yogurt purchased at an other venue?  
YogurtRestaurant  
VenueYogurt2  
VenueYogurt3  
VenueYogurt4  
DetailsYogurt2  
DetailsYogurt3  
DetailsYogurt4  
IfEatenPotato  
DeliCounterPotato  
DetailsPotato  
VenuePotato  
IfEatenPasta  
DeliCounterPasta  
DetailsPasta  
VenuePasta  
IfEatenEgg  
DeliCounterEgg  
DetailsEgg  
VenueEgg  
IfEatenTuna  
DeliCounterTuna  
DetailsTuna  
VenueTuna  
IfEatenChickenSalad  
DeliCounterChickenSalad  
DetailsChickenSalad  
VenueChickenSalad  
IfEatenBeanSalad  
DeliCounterBeanSalad  
DetailsBeanSalad  
VenueBeanSalad  
IfEatenSeafoodSalad  
DeliCounterSeafoodSalad  
DetailsSeafoodSalad  
VenueSeafoodSalad  
IfEatenColeSlaw  
DeliCounterColeSlaw  
DetailsColeSlaw  
VenueColeSlaw  
Other ready to eat meat or vegetable salad

Other ready to eat meat or vegetable salad: Other  
Other ready to eat meat or vegetable salad: Details  
Other ready to eat meat or vegetable salad: Venue  
IfEatenSaladBar  
DetailsSaladBar  
VenueSaladBar  
IfEatenSmoothie  
DetailsSmoothie  
VenueSmoothie  
IfEatenTahini  
DetailsTahini  
VenueTahini  
IfEatenTofu  
DetailsTofu  
VenueTofu  
IfEatenRiceNoodle  
DetailsRiceNoodle  
VenueRiceNoodle  
IfEatenSandwich  
DetailsSandwich  
VenueSandwich  
IfEatenNutButter  
DetailsNutButter  
VenueNutButter  
IfEatenNuts  
DetailsNuts  
VenueNuts  
IfEatenSeeds  
DetailsSeeds  
VenueSeeds  
IfEatenOtherCountry  
DetailsOtherCountry  
VenueOtherCountry  
BeanSaladOften  
BeanSaladDeli  
BeanSaladGrocery  
BeanSaladOther  
BeanSaladRestaurant  
VenueBeanSalad2  
VenueBeanSalad3  
VenueBeanSalad4  
DetailsBeanSalad2  
DetailsBeanSalad3  
DetailsBeanSalad4  
ColeSlawOften  
ColeSlawDeli  
ColeSlawGrocery

ColeSlawOther  
ColeSlawRestaurant  
VenueColeSlaw2  
VenueColeSlaw3  
VenueColeSlaw4  
DetailsColeSlaw2  
DetailsColeSlaw3  
DetailsColeSlaw4  
OtherRTESaladSpecify  
OtherRTESaladOften  
OtherRTESaladDeli  
OtherRTESaladGrocery  
OtherRTESaladOther  
OtherRTESaladRestaurant  
VenueOtherRTESalad2  
VenueOtherRTESalad3  
VenueOtherRTESalad4  
DetailsOtherRTESalad2  
DetailsOtherRTESalad3  
DetailsOtherRTESalad4  
If at pasta salad, how often?  
Was pasta salad purchased from a deli/small market?  
Was pasta salad purchased from a grocery store?  
Was pasta salad purchased from an other venue?  
PastaRestaurant  
VenuePasta2  
VenuePasta3  
VenuePasta4  
DetailsPasta2  
DetailsPasta3  
DetailsPasta4  
If ate potato salad, how often?  
Was potato salad purchased from a deli/small market?  
Was potato salad purchased from a grocery store?  
Was potato salad purchased at an other venue?  
PotatoRestaurant  
VenuePotato2  
VenuePotato3  
VenuePotato4  
DetailsPotato2  
DetailsPotato3  
DetailsPotato4  
SeafoodSaladOften  
SeafoodSaladDeli  
SeafoodSaladGrocery  
SeafoodSaladOther  
SeafoodSaladRestaurant

VenueSeafoodSalad2

VenueSeafoodSalad3

VenueSeafoodSalad4

DetailsSeafoodSalad2

DetailsSeafoodSalad3

DetailsSeafoodSalad4

If ate tuna salad, how often?

Was tuna salad purchase from a deli/small market?

Was tuna salad purchase from a grocery store?

Was tuna salad purchase from an other venue?

TunaRestaurant

VenueTuna2

VenueTuna3

VenueTuna4

DetailsTuna2

DetailsTuna3

DetailsTuna4

IfEatenApples

FruitStateApple

PreSlicedApple

VenueApple

DetailsApple

IfEatenCarApple

DetailsCarApple

VenueCarApple

IfEatenGrape

DetailsGrape

VenueGrape

IfEatenRaisin

DetailsRaisin

VenueRaisin

IfEatenPear

FruitStatePear

DetailsPear

VenuePear

IfEatenPeach

DetailsPeach

FruitStatePeach

VenuePeach

IfEatenNectarine

FruitStateNectarine

DetailsNectarine

VenueNectarine

IfEatenApricot

FruitStateApricot

DetailsApricot

VenueApricot

IfEatenPlum  
DetailsPlum  
FruitStatePlum  
VenuePlum  
IfEatenStrawberry  
DetailsStrawberry  
FruitStateStrawberry  
VenueStrawberry  
IfEatenRaspberry  
DetailsRaspberry  
FruitStateRaspberry  
VenueRaspberry  
IfEatenBlueberry  
FruitStateBlueberry  
DetailsBlueberry  
VenueBlueberry  
IfEatenBlackberry  
FruitStateBlackberry  
DetailsBlackberry  
VenueBlackberry  
IfEatenCherry  
FruitStateCherry  
DetailsCherry  
VenueCherry  
IfEatenHoneydew  
DetailsHoneydew  
PreSlicedHoneydew  
VenueHoneydew  
IfEatenCantaloupe  
PreSlicedCantaloupe  
DetailsCantaloupe  
VenueCantaloupe  
IfEatenWatermelon  
PreSlicedWatermelon  
DetailsWatermelon  
VenueWatermelon  
IfEatenPineapple  
PreSlicedPineapple  
DetailsPineapple  
VenuePineapple  
IfEatenMango  
PreSlicedMango  
FruitStateMango  
DetailsMango  
VenueMango  
IfEatenPapaya  
FruitStatePapaya

DetailsPapaya  
VenuePapaya  
IfEatenAvocado  
DetailsAvocado  
VenueAvocado  
FruitStateAvocado  
IfEatenFruitSalad  
DetailsFruitSalad  
VenueFruitSalad  
IfEatenOtherFruit  
SpecifyOtherFruit  
FruitStateOtherFruit  
DetailsOtherFruit  
VenueOtherFruit  
IfEatenSorbet  
DetailsSorbet  
VenueSorbet  
Spent time at a petting zoo  
Spent time at a petting zoo: Details  
Spent time at a petting zoo: Venue  
Fed cat or dog raw pet food  
Fed cat or dog raw pet food: Details  
Fed cat or dog raw pet food: Venue  
Fed cat or dog refrigerated, frozen, or freeze-dried treats  
Fed cat or dog refrigerated, frozen, or freeze-dried treats: Venue  
Fed cat or dog refrigerated, frozen, or freeze-dried treats: Details  
FruitSaladOften  
FruitSaladDeli  
FruitSaladGrocery  
FruitSaladOther  
FruitSaladRestaurant  
VenueFruitSalad2  
VenueFruitSalad3  
VenueFruitSalad4  
DetailsFruitSalad2  
DetailsFruitSalad3  
DetailsFruitSalad4  
DeliCounterFruitSalad  
CantaloupeOften  
CantaloupeDeli  
CantaloupeGrocery  
CantaloupeOther  
CantaloupeRestaurant  
VenueCantaloupe2  
VenueCantaloupe3  
VenueCantaloupe4  
DetailsCantaloupe2

DetailsCantaloupe3  
DetailsCantaloupe4  
If ate honeydew, how often?  
Was honeydew purchased at a deli/small market?  
Was honeydew purchased at a grocery store?  
Was honeydew purchased at an other venue?  
HoneydewRestaurant  
VenueHoneydew2  
VenueHoneydew3  
VenueHoneydew4  
DetailsHoneydew2  
DetailsHoneydew3  
DetailsHoneydew4  
WatermelonOften  
WatermelonDeli  
WatermelonGrocery  
WatermelonOther  
WatermelonRestaurant  
VenueWatermelon2  
VenueWatermelon3  
VenueWatermelon4  
DetailsWatermelon2  
DetailsWatermelon3  
DetailsWatermelon4  
Case classification of Pregnant mother  
Case classification of Neonate  
Case classification  
Laboratory Criteria for Diagnosis  
Neonatal age at time of laboratory specimen collection  
Result of culture-based test on specimen  
Result of CIDT-based test on specimen  
Indicates the case is epi-linked to a confirmed or probable case  
Pregnant: If infant died, when was the date of death (Date)  
Pregnant: If mother and infant are counted as separate cases provide the State Epi Case ID of the mother  
Pregnant: If mother and infant are counted as separate cases provide the State Epi Case ID of the neonate

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)    CDC Priority (New)

Bloodstream infection/sepsis  
Meningitis  
Meningoencephalitis

Brain abscess  
Rhombencephalitis  
Peritonitis  
Pneumonia  
Wound infection  
Joint infection/septic arthritis  
Bone infection/osteomyelitis  
Other illness  
Other illness specify  
Unknown

ed case

te?

or farmers market 1

or farmers market 2

or farmers market 3

or farmers market 4

or farmers market 5

or farmers market 6

or farmers market 7

ops, or farmers' markets during the 4 week period?

a, concession stands, street vendors, institutions (e.g., hospital food), local farms, or private vendors during the  
aurants during the 4 week period?

|                           |     |
|---------------------------|-----|
| PHVS_CaseClassStatus_NND  | TBD |
| PHVS_CaseClassStatus_NND  | TBD |
| PHVS_CaseClassStatus_NND  | TBD |
|                           | TBD |
|                           | TBD |
| PHVS_PosNegUnkNotDone_CDC | TBD |
| PHVS_PosNegUnkNotDone_CDC | TBD |
| PHVS_YesNoUnknown_CDC     | TBD |
|                           | TBD |
|                           | TBD |

4 week period?

Label/Short Name  
TB State Case Number

City or County Case Number  
Birth Sex  
Previously Counted Case  
Previously Reported State Case  
Number  
Country of Verified Case

Patient Address City  
Inside City Limits

Census Tract of Case-Patient Residence

Detailed Race  
Date Arrived in US

US Born

Primary Guardian(s) Country of Birth

Remain in US After Report

Initial Reason for Evaluation

Test Type

Test Result

Date/Time of Lab Result

Specimen Source Site

Specimen Collection Date/Time

Test Result Quantitative

Result Units  
Type of Chest Study

Result of Chest Study

Evidence of Cavity

Evidence of Miliary TB

Date of Chest Study  
Current Occupation

Current Occupation Standardized

Current Industry

Current Industry Standardized

Patient Epidemiological Risk Factors

Patient Epidemiological Risk Factors  
Indicator

Type of Correctional Facility

Type of Long-Term Care Facility

Smoking Status  
Patient lived outside of US for more  
than 2 months

Identified During Contact Investigation

Evaluation During Contact Investigation

Linked Case Number  
Date Treatment or Therapy Started  
Treatment Administration Type

Date Treatment or Therapy Stopped  
Treatment Started

Initial LTBI Drug Regimen

Primary Reason LTBI Treatment Not  
Started  
Reason LTBI Treatment Stopped

NTSS State Case Number  
Adverse Event Severity

Usual Occupation and Industry  
Meets Binational Reporting Criteria

|                                                                                                                                                                                                                                                     |                                                                                                                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                     | Value Set Code. Search in PHIN VADS using the following link ( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) |
| Description                                                                                                                                                                                                                                         |                                                                                                                                                                                |
| State case number for the case specific to TB investigations (4 digit report year + 2 letter state + 9 digit alphanumeric number)                                                                                                                   | N/A                                                                                                                                                                            |
| City or county case number assigned to this case                                                                                                                                                                                                    | N/A                                                                                                                                                                            |
| What was the patient's sex at birth?                                                                                                                                                                                                                | PHVS_Sex_MFU                                                                                                                                                                   |
| Has this case already been counted by another reporting area?                                                                                                                                                                                       | PHVS_CaseCountStatus_TB                                                                                                                                                        |
| If case previously counted, provide the state case number from the other reporting area.                                                                                                                                                            | N/A                                                                                                                                                                            |
| If the case was previously reported by another country, specify the country.                                                                                                                                                                        | PHVS_BirthCountry_CDC                                                                                                                                                          |
| Patient address city                                                                                                                                                                                                                                | N/A                                                                                                                                                                            |
| Is the patient's residence within city limits?                                                                                                                                                                                                      | PHVS_YesNoUnknown_CDC                                                                                                                                                          |
| Census tract where the address is located is a unique identifier associated with a small statistical subdivision of a county. Census tract data allows a user to find population and housing statistics about a specific part of an urban area.     | N/A                                                                                                                                                                            |
| Provide the detailed race information for the patient.                                                                                                                                                                                              | PHVS_Race_CDC                                                                                                                                                                  |
| If country of birth is NOT United States, regardless of citizenship, indicate the date when the patient first arrived in the US.                                                                                                                    | N/A                                                                                                                                                                            |
| Was the patient eligible for US citizenship at birth?                                                                                                                                                                                               | PHVS_YesNoUnknown_CDC                                                                                                                                                          |
| Indicates the birth country of the primary guardian(s) of patient (pediatric [<15 years old] cases only)                                                                                                                                            | PHVS_BirthCountry_CDC                                                                                                                                                          |
| If not US reporting area, did patient remain in the United States for >= 90 days after report date?                                                                                                                                                 | PHVS_YesNoUnknown_CDC                                                                                                                                                          |
| What was the initial reason the patient was evaluated for TB?                                                                                                                                                                                       | PHVS_PrimaryReasonForEvaluation_TB                                                                                                                                             |
| Epidemiologic interpretation of the type of test(s) performed for this case. Please provide a response for each of the main test types (culture, smear, pathology/cytology, NAA, TST, IGRA, HIV, diabetes) If test was not done please indicate so. | PHVS_LabTestType_TB                                                                                                                                                            |
| Epidemiologic interpretation of the results of the test(s) performed for this case - This is a qualitative test result. (e.g., positive, detected, negative)                                                                                        | PHVS_LabTestInterpretation_TB                                                                                                                                                  |
| Date result sent from reporting laboratory. Time of result is an optional addition to date.                                                                                                                                                         | N/A                                                                                                                                                                            |
| This indicates the anatomical source of the specimen tested.                                                                                                                                                                                        | PHVS_MicroscopicExamCultureSite_TB                                                                                                                                             |
| Date of collection of laboratory specimen used for diagnosis of health event reported in this case report. Time of collection is an optional addition to date.                                                                                      | N/A                                                                                                                                                                            |
| Quantitative test result value                                                                                                                                                                                                                      | N/A                                                                                                                                                                            |

|                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| Units of measure for the Quantitative Test Result Value                                                                                                                                                                                                                                                                                                                                                                         | PHVS_UnitofMeasure_TB              |
| Indicate the type of chest study performed. Please provide a response for each of the main test types (plain chest radiograph, chest CT Scan) and if test was not done please indicate so.                                                                                                                                                                                                                                      | PHVS_TypeofRadiologyStudy_CDC      |
| Result of chest diagnostic testing                                                                                                                                                                                                                                                                                                                                                                                              | PHVS_ResultofRadiologyStudy_TB     |
| Did test show evidence of cavity?                                                                                                                                                                                                                                                                                                                                                                                               | PHVS_YesNoUnknown_CDC              |
| Did test show evidence of miliary TB?                                                                                                                                                                                                                                                                                                                                                                                           | PHVS_YesNoUnknown_CDC              |
| Date of the chest diagnostic study                                                                                                                                                                                                                                                                                                                                                                                              | N/A                                |
| This data element is used to capture the narrative text of a subject's current occupation.                                                                                                                                                                                                                                                                                                                                      | N/A                                |
| This data element is used to capture the CDC NIOSH standard occupation code based upon the narrative text of a subject's current occupation.                                                                                                                                                                                                                                                                                    | PHVS_Occupation_CDC_Census2010     |
| (The National Institute for Occupational Safety and Health (NIOSH) has developed a web-based software tool designed to translate industry and occupation text to standardized Industry and Occupation codes. The NIOSH Industry and Occupational Computerized Coding System (NIOCCS) is available here: <a href="http://www.cdc.gov/niosh/topics/coding/overview.html">http://www.cdc.gov/niosh/topics/coding/overview.html</a> |                                    |
| This data element is used to capture the narrative text of subject's current industry.                                                                                                                                                                                                                                                                                                                                          | N/A                                |
| This data element is used to capture the CDC NIOSH standard industry code based upon the narrative text of a subject's current industry.                                                                                                                                                                                                                                                                                        | PHVS_Industry_CDC_Census2010       |
| (The National Institute for Occupational Safety and Health (NIOSH) has developed a web-based software tool designed to translate industry and occupation text to standardized Industry and Occupation codes. The NIOSH Industry and Occupational Computerized Coding System (NIOCCS) is available here: <a href="http://www.cdc.gov/niosh/topics/coding/overview.html">http://www.cdc.gov/niosh/topics/coding/overview.html</a> |                                    |
| Exposed risk factors for the patient - Please provide a response for all risk factors in the value set with an associated indicator                                                                                                                                                                                                                                                                                             | PHVS_EpidemiologicalRiskFactors_TB |
| Provide a response for each value in the patient epidemiological risk factors value set                                                                                                                                                                                                                                                                                                                                         | PHVS_YesNoUnknown_CDC              |
| If patient was a Resident of Correctional Facility at Diagnostic Evaluation, indicate the type of correctional facility.                                                                                                                                                                                                                                                                                                        | PHVS_CorrectionalFacilityType_NND  |
| If patient was a Resident of Long Term Care Facility at Diagnostic Evaluation, indicate the type of long term care facility.                                                                                                                                                                                                                                                                                                    | PHVS_LongTermCareFacilityType_NND  |
| What is the patient's current tobacco smoking status?                                                                                                                                                                                                                                                                                                                                                                           | PHVS_SmokingStatus_CDC             |
| Residence or Travel in countries other than the United States, Canada, Australia, New Zealand, or countries in northern or western Europe for >60 consecutive days at any point in the patient's lifetime.                                                                                                                                                                                                                      | PHVS_YesNoUnknown_CDC              |
| Was the patient identified during the contact investigation around the likely source case?                                                                                                                                                                                                                                                                                                                                      | PHVS_YesNoUnknown_CDC              |

|                                                                                                                            |                                     |
|----------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| If patient was identified during contact investigation, was the patient evaluated for TB during the contact investigation? | PHVS_YesNoUnknown_CDC               |
| State case numbers for epidemiologically linked cases                                                                      | N/A                                 |
| Date the initial treatment regimen was started                                                                             | N/A                                 |
| Choose all treatment administration types that apply to the case, such as DOT, eDOT, or SAT.                               | PHVS_TreatmentAdministrationType_TB |
| Date treatment stopped                                                                                                     | N/A                                 |
| Was treatment started for LTBI?                                                                                            | PHVS_YesNoUnknown_CDC               |
| If treatment was started indicate the initial LTBI drug regimen.                                                           | PHVS_LTBIDrugRegimen_TB             |
| If treatment was not started, what was the primary reason LTBI treatment was not started?                                  | PHVS_ReasonLTBINotStarted_TB        |
| Reason LTBI treatment stopped                                                                                              | PHVS_ReasonLTBITreatmentStopped_TB  |
| If patient developed TB from LTBI, list the NTSS state case number                                                         | N/A                                 |
| If treatment was stopped due to adverse event from LTBI treatment indicate the severity.                                   | PHVS_AdverseEventSeverity_TB        |
| Usual occupation and industry                                                                                              | TBD                                 |
| Does case meet binational reporting criteria?                                                                              | PHVS_YesNoUnknown_CDC               |

CDC Priority

P

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Label/Short Name

Erythema Migrans

Swelling

Bell's Palsy or other cranial neuritis

Radiculoneuropathy

Lymphocytic meningitis

Encephalitis/Encephalomyelitis

2nd or 3rd degree atrioventricular  
block

OtherSpeci

Results

EIA\_IFA test type

EIA\_IFA test result

Immunoblot result

IgM\_21kDa

IgM\_39kDa

IgM\_41kDa

IgG\_18kDa

IgG\_21kDa

IgG\_28kDa

IgG\_30kDa

IgG\_39kDa

IgG\_41kDa

IgG\_45kDa

IgG\_58kDa

IgG\_66kDa

IgG\_93kDa

Exposure in high incidence state

Symptom onset greater than 30 days

Clinical Manifestation

Clinical Manifestation Indicator

Medication Administered

Date Treatment or Therapy Started

Treatment Duration

## Description

Indicates whether the patient had erythema migrans (physician diagnosed EM at least 5 cm in diameter).

Indicates whether the patient had arthritis characterized by brief attacks of joint swelling.

Indicates whether the patient had Bell's palsy or other cranial neuritis.

Indicates whether the patient had radiculoneuropathy.

Indicates whether the patient had lymphocytic meningitis.

Indicates whether the patient had encephalitis/encephalomyelitis.

Indicates whether the patient had 2nd or 3rd degree atrioventricular block.

Name of another laboratory test performed

Result of other specific laboratory tests performed

Type of EIA performed

Result of EIA

Result of immunoblot

Immunoblot specific test result; linked to laboratory criteria

Immunoblot specific test result; linked to laboratory criteria

Immunoblot specific test result; linked to laboratory criteria

Immunoblot specific test result; linked to laboratory criteria

Immunoblot specific test result; linked to laboratory criteria

Immunoblot specific test result; linked to laboratory criteria

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Immunoblot specific test result; linked to laboratory criteria

Immunoblot specific test result; linked to laboratory criteria

Immunoblot specific test result; linked to laboratory criteria

Immunoblot specific test result; linked to laboratory criteria

Did patient live in or visit a state defined as high incidence within 30 days prior to onset of symptoms?

Did onset of symptoms occur more than 30 days prior to diagnosis?

Clinical manifestation of Lyme disease

For each clinical manifestation reported, indicate whether the subject developed the specified manifestation as a result of the illness.

What antibiotic did the patient receive for this episode?

Date the treatment or therapy was initiated

Number of days the patient actually took the antibiotic referenced

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

TEXT

P/N/E/ND/U

Whole cell antigen EIA/ELISA/ELFA; Defined antigen EIA/ELISA/ELFA;Antigen capture  
EIA/ELISA/ELFA; IFA; Unknown; Other; not done

IgM positive only; IgG positive only; IgM and IgG positive; negative; unknown; not done

IgM positive only; IgG positive only; IgM and IgG positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

positive; negative; unknown; not done

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_ClinicalManifestations\_Lyme

PHVS\_YesNoUnknown\_CDC

PHVS\_MedicationReceived\_Lyme

N/A

N/A

CDC Priority

P

P

P

P

P

P

P

Label/Short Name

Height

Height Units

Weight

Weight Units

Hospital Name

Hospital Record Number

Patient last name

Patient first name

Physician last name

Physician first name

Physician phone number

Laboratory Name

Laboratory Phone Number

Specimen(s) sent to CDC?

Specimen Type(s) sent to CDC

Description of other specimen type

Test Type

Organism Name

Description of other organism

Parasitemia Level Percentage

Subject Traveled or Lived Outside  
U.S.

Subject Reside in U.S. prior to most  
recent travel

Subject's Country of Residence prior  
to most recent travel

Principal reason for Travel

Description of other reason for travel

International Destination(s) or  
residence(s) #1

Date of return from travel #1

Duration of Stay #1

Duration of Stay Units #1

International Destination(s) or  
residence(s) #2

Date of return from travel #2

Duration of Stay #2

Duration of Stay Units #2

International Destination(s) or residence(s) #3

Date of return from travel #3

Duration of Stay #3

Duration of Stay Units #3

Was malaria chemoprophylaxis taken?

Preventative Medication(s)

Description of other malaria chemoprophylaxis taken

Preventative Medication taken as prescribed?

If doses were missed, what was the reason?

Specific side effect that caused missed doses

Description of the Other reason for missing chemoprophylaxis doses

History of malaria past 12 months

Date of previous malaria attack

Malaria species associated with previous attack

Description of other malaria species associated with previous attack

Received blood transfusion/organ transplant

Blood transfusion/organ transplant date

Complication(s)

Other complication(s)

Treatment Medication(s)

Other treatment medication(s)

Medications pre-treatment

Medications post-treatment

Malaria treatment taken as prescribed

Symptoms resolved within 7 days after treatment

Recurrence of symptoms during 4 weeks after treatment

Adverse events within 4 weeks after starting treatment

Adverse Event #1 description

Adverse Event #1 relationship to treatment

Adverse Event #1 time to onset

Adverse Event #1 fatal

Adverse Event #1 life-threatening

Adverse Event #1 other seriousness

Adverse Event #2 description

Adverse Event #2 relationship to treatment

Adverse Event #2 time to onset

Adverse Event #2 fatal

Adverse Event #2 life-threatening

Adverse Event #2 other seriousness

Adverse Event #3 description

Adverse Event #3 relationship to treatment

Adverse Event #3 time to onset

Adverse Event #3 fatal

Adverse Event #3 life-threatening

Adverse Event #3 other seriousness

Adverse Event #4 description

Adverse Event #4 relationship to treatment

Adverse Event #4 time to onset

Adverse Event #4 fatal

Adverse Event #4 life-threatening

Adverse Event #4 other seriousness

Adverse Event #5 description

Adverse Event #5 relationship to treatment

Adverse Event #5 time to onset

Adverse Event #5 fatal

Adverse Event #5 life-threatening

Adverse Event #5 other seriousness

CSID

Admitted as Inpatient  
Date Treatment or Therapy Started  
Date Treatment or Therapy Stopped  
Treatment Duration  
Medication Administered Relative to  
Treatment

Medication Administered

Medication Start Date  
Medication Stop Date  
Medication Duration  
Mother's Local Record ID

## Description

Subject's height

Subject's height units

Subject's weight

Subject's weight units

Name of hospital where case was admitted

Hospital Record Number, if subject was hospitalized

Patient's last name

Patient's first name

Last name of physician seen for this case

First name of physician seen for this case

Phone number of the physician seen for this case

Reporting Laboratory Name

Reporting Laboratory Phone Number

Was specimen sent to CDC for Malaria confirmation?

Type(s) of specimen sent to CDC.

Description of the other type of specimen sent to CDC

Epidemiologic interpretation of the type of test(s) performed for this case.

Species identified through testing.

Description of the other organism tested positive for

The estimated number of infected erythrocytes expressed as a percentage of the total erythrocytes.

Has the subject traveled or lived outside the U.S. during the past two years?

Did the subject reside in the U.S. prior to most recent travel?

If the subject did not reside in the U.S. prior to most recent travel, what was the country of residence?

If the subject did not reside in the U.S. prior to most recent travel, what was the country of residence?

Description of the other reason for travel from/to the US

Destination(s) or residence(s) outside the U.S. during the past 2 years

Date the subject returned/arrived to the U.S. from an international destination or residence.

Duration of stay in country outside the U.S.

Duration of stay units in country outside the U.S.

Destination(s) or residence(s) outside the U.S. during the past 2 years

Date the subject returned/arrived to the U.S. from an international destination or residence.

Duration of stay in country outside the U.S.

Duration of stay units in country outside the U.S.

Destination(s) or residence(s) outside the U.S. during the past 2 years

Date the subject returned/arrived to the U.S. from an international destination or residence.

Duration of stay in country outside the U.S.

Duration of stay units in country outside the U.S.

Was malaria chemoprophylaxis taken for prevention of malaria?

Listing of preventative medication(s) taken by the subject

Description of the other type of malaria chemoprophylaxis taken

Was all preventative medication taken as prescribed?

If doses of preventative medicine were missed, what was the primary reason?

Description of the side effect that was the reason for missing doses of malaria chemoprophylaxis

Description of the other reason that resulted in missing doses of malaria chemoprophylaxis

Does the subject have a previous history of malaria in the last 12 months (prior to this report)?

Date of previous malaria attack

Malaria species associated with previous attack

Description of the other malaria species associated with the malaria attack in the past 12 months

Has the subject received a blood transfusion or organ transplant within the last 12 months?

If subject has received a blood transfusion/organ transplant within the last 12 months, what was the date?

Listing of complications as related to this attack.

Description of the other clinical complications experienced during this episode/attack of malaria

Listing of treatment medication the subject received for this attack.

Description of the other treatment medications received for this attack

List of all medications taken during the 2 weeks before starting treatment for malaria

List of all medications taken during the 4 weeks after starting treatment for malaria

Was the medicine for malaria treatment taken as prescribed?

Did all signs or symptoms of malaria resolve without any additional malaria treatment within 7 days after starting treatment?

If signs and symptoms resolved within 7 days after starting treatment, did the patient experience a recurrence of signs or symptoms of malaria during 4 weeks after starting treatment?

Did the patient experience any adverse events within 4 weeks after receiving the malaria treatment

Adverse Event description

Is it suspected a causal relationship between the treatment and the adverse event is at least a reasonable possibility?

Time to onset since starting treatment

Was the adverse event fatal?

Was the adverse event life-threatening?

Was the adverse event serious in another way (i.e., significant disability/incapacity, medically significant, requiring hospitalization or prolonging of existing hospitalization)?

Adverse Event description

Is it suspected a causal relationship between the treatment and the adverse event is at least a reasonable possibility?

Time to onset since starting treatment

Was the adverse event fatal?

Was the adverse event life-threatening?

Was the adverse event serious in another way (i.e., significant disability/incapacity, medically significant, requiring hospitalization or prolonging of existing hospitalization)?

Adverse Event description

Is it suspected a causal relationship between the treatment and the adverse event is at least a reasonable possibility?

Time to onset since starting treatment

Was the adverse event fatal?

Was the adverse event life-threatening?

Was the adverse event serious in another way (i.e., significant disability/incapacity, medically significant, requiring hospitalization or prolonging of existing hospitalization)?

Adverse Event description

Is it suspected a causal relationship between the treatment and the adverse event is at least a reasonable possibility?

Time to onset since starting treatment

Was the adverse event fatal?

Was the adverse event life-threatening?

Was the adverse event serious in another way (i.e., significant disability/incapacity, medically significant, requiring hospitalization or prolonging of existing hospitalization)?

Adverse Event description

Is it suspected a causal relationship between the treatment and the adverse event is at least a reasonable possibility?

Time to onset since starting treatment

Was the adverse event fatal?

Was the adverse event life-threatening?

Was the adverse event serious in another way (i.e., significant disability/incapacity, medically significant, requiring hospitalization or prolonging of existing hospitalization)?

10-digit, de-identified specimen number generated after submission of the 50.34 form for CDC diagnostic assistance (Example data: 3000123456)

Was subject admitted to the hospital for greater than 24 hours as an inpatient?

Date the treatment was initiated

Date treatment stopped

Number of days the patient was prescribed antimalarial treatment

Indicate if the patient took the medication 2 weeks before treatment or within the 4 weeks after starting treatment.

Please list all prescription and over the counter medicines the patient had taken during the 2 weeks before and during the 4 weeks after starting treatment for malaria. If information for both pre- and post-treatment are available, please complete below questions for each time frame.

Medication Start Date

Medication Stop Date

Number of days that patient took the medication referenced

Provide the local record ID used for reporting mother's case (DE Identifier "N/A: OBR-3" in the Generic portion of the message). This will be used for linking the reported congenital case to the mother's reported case.

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_HeightUnit\_UCUM

PHVS\_WeightUnit\_UCUM

free text

free text

free text

free text

free text

PHVS\_YesNoUnknown\_CDC

PHVS\_SpecimenType\_Malaria

free text

PHVS\_LabTestProcedure\_Malaria

PHVS\_Species\_Malaria

free text

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_Country\_ISO\_3166-1

PHVS\_TravelReason\_Malaria

free text

PHVS\_Country\_ISO\_3166-1

PHVS\_AgeUnit\_UCUM

PHVS\_Country\_ISO\_3166-1

PHVS\_AgeUnit\_UCUM

PHVS\_Country\_ISO\_3166-1

PHVS\_AgeUnit\_UCUM

PHVS\_YesNoUnknown\_CDC

PHVS\_MedicationProphylaxis\_Malaria

free text

PHVS\_YesNoUnknown\_CDC

PHVS\_MedicationMissedReason\_Malaria

free text

free text

PHVS\_YesNoUnknown\_CDC

PHVS\_Species\_Malaria

free text

PHVS\_YesNoUnknown\_CDC

PHVS\_Complications\_Malaria

free text

PHVS\_MedicationTreatment\_Malaria

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PHVS\_YesNoUnknown\_CDC

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PHVS\_YesNoUnknown\_CDC

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|------------------------------------------------------|---|
| PHVS_YesNoUnknown_CDC                                | P |
| N/A                                                  | P |
| N/A                                                  | P |
| N/A                                                  | P |
| PHVS_MedicationAdministeredRelativeTreatment_Malaria | P |
| N/A                                                  | P |
| N/A                                                  | P |
| N/A                                                  | P |
| N/A                                                  | P |
| N/A                                                  |   |

CDC Priority (New)



Label/Short Name

Did the subject have a rash?

Rash onset date

Rash Duration

Was the rash generalized?

Rash onset occur within 21 days of  
entering USA

Did the subject have a fever?

Highest Measured Temperature

Temperature units

Date of fever onset

Cough

Coryza (runny nose)

Conjunctivitis

Otitis Media (Complication)

Diarrhea (Complication)

Pneumonia (Complication)

Encephalitis (Complication)

Thrombocytopenia (Complication)

Croup (Complication)

Hepatitis (Complication)

Other Complication

Specify Other Complication

Was laboratory testing done for  
measles?

Test Type

Test Result

Sample Analyzed Date

Test Method

Date Collected

Specimen Source

Were the specimens sent to CDC for  
genotyping (molecular typing)?

Specimen type sent to CDC for  
genotyping

Date sent for genotyping

Was Measles virus genotype  
sequenced?

Type of Genotype Sequence

Transmission Setting

Source of Infection

Were age and setting verified?

Is this case Epi-linked to another confirmed or probable case?

Is this case linked to an international imported case either directly or within same chain of transmission?

International Destination(s) of recent travel

Date of return from travel.

Did the subject ever receive a disease-containing vaccine?

If no, reason subject did not receive a disease-containing vaccine

Number of doses received BEFORE first birthday

Number of doses received ON or AFTER first birthday

Reason for vaccinating before first (1st) birthday but not after

Reason subject received one dose ON or AFTER first birthday, but never received a second dose after the first (1st) birthday

Total doses disease-containing vaccine

Vaccine Administered

Vaccine Manufacturer

Vaccine Lot Number

Vaccine Administered Date

US Acquired

Age at Rash Onset

Age Type at rash Onset

Chest x-ray for pneumonia

Case Patient a Healthcare Worker

Import Status

Vaccination Doses Prior to Illness Onset

Date of Last Dose Prior to Illness Onset

Vaccine History Comments

## Description

Did the subject being reported in this investigation have a rash?

What was the onset date of the subject's rash?

How many days did the rash reported in this investigation last?

Was the rash generalized? (Occurring on more than one or two parts of the body?)

Did rash onset occur within 21 days of entering the USA, following any travel or living outside the USA?

Did the subject have a fever? I.E., a measured temperature >2 degrees above normal

What was the subject's highest measured temperature during this illness?

The units of measure of the highest measured temperature. This would be either Fahrenheit or Celsius.

Date of fever onset

Did the subject develop a cough during this illness?

Did the subject develop coryza (runny nose) during this illness?

Did the subject develop conjunctivitis during this illness?

Did the subject develop otitis media as a complication of this illness?

Did the subject develop diarrhea as a complication of this illness?

Did the subject develop pneumonia as a complication of this illness?

Did the subject develop encephalitis as a complication of this illness?

Did the subject develop thrombocytopenia as a complication of this illness?

Did the subject develop croup as a complication of this illness?

Did the subject develop hepatitis as a complication of this illness?

Did the subject develop other conditions as a complication of this illness?

Please specify the other complication the subject developed, during or as a result of this illness.

Was laboratory testing done to confirm a diagnosis of measles?

Epidemiologic interpretation of the type of test(s) performed for this case

Epidemiologic interpretation of the results of the tests performed for this case.

The date the specimen/isolate was tested.

The technique or method used to perform the test and obtain the test results.

Date of specimen collection

The medium from which the specimen originated.

Were clinical specimens sent to CDC laboratories for genotyping (molecular typing)?

Specimen type sent to CDC for genotyping

The date the specimens were sent to the CDC laboratories for genotyping.

Identifies whether the Measles virus was genotype sequenced.

Identifies the genotype sequence of the Measles virus

What was the transmission setting where the measles was acquired?

What was the source of the measles infection?

Does the age of the case match or make sense for the transmission setting listed (i.e. A subject aged 80 probably would not have a transmission setting of child day care center.)?

Specify if this case is Epidemiologically-linked to another confirmed or probable case of measles?

A "Yes" answer to this question denotes this case was infected by another subject who acquired infection while outside of the U.S.

List any international destinations of recent travel

Date the subject returned from all travel

Did the subject ever receive a measles-containing vaccine?

If the subject did not receive a measles-containing vaccine, what was the reason?

The number of doses of measles-containing vaccine the subject received before their first birthday.

The number of measles-containing vaccine doses the subject received on or after their first birthday.

If the subject was vaccinated with measles-containing vaccine BEFORE the first birthday, but did not receive a vaccine dose after their first birthday, state the reason.

If the subject received one dose of measles-containing vaccine ON or AFTER their first birthday, but did not receive a second dose after the first birthday, what was the reason?

Total doses measles-containing vaccine

The type of vaccine administered

Manufacturer of the vaccine

The vaccine lot number of the vaccine administered

The date that the vaccine was administered

Sub-classification of disease or condition acquired in the US

Age of patient at rash onset

Age units of patient at rash onset

Was a chest x-ray for pneumonia done?

Was the case patient a healthcare provider (HCP) at illness onset?

Was this case imported?

Number of vaccine doses against this disease prior to illness onset

Date of last vaccine dose against this disease prior to illness onset

Comments about the subject's vaccination history

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_TemperatureUnit\_UCUM

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_LabTestProcedure\_Measles

PHVS\_LabTestInterpretation\_VPD

PHVS\_LabTestMethod\_CDC

PHVS\_SpecimenSource\_Measles

PHVS\_YesNoUnknown\_CDC

PHVS\_SpecimenSource\_Measles

PHVS\_YesNoUnknown\_CDC

PHVS\_Genotype\_Measles

PHVS\_TransmissionSetting\_NND

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_Country\_ISO\_3166-1

PHVS\_YesNoUnknown\_CDC

PHVS\_VaccineNotGivenReasons\_CDC

PHVS\_VaccineNotGivenReasons\_CDC

PHVS\_VaccineNotGivenReasons\_CDC

PHVS\_VaccinesAdministeredCVX\_CDC\_NIP

PHVS\_ManufacturersOfVaccinesMVX\_CDC\_NIP

PHVS\_CaseClassificationExposureSource\_NND

Label/Short Name

State Case ID

Date of First Report to CDC

Notification Result Status

Condition Code

Case Class Status Code

MMWR Week

MMWR Year

Reporting State

Reporting County

National Reporting Jurisdiction

Reporting Source Type Code

Reporting Source ZIP Code

Date First Reported PHD

Person Reporting to CDC - Name

Person Reporting to CDC - Phone Number

Person Reporting to CDC - Title

Person Reporting to CDC - Affiliation

Subject Address County

Subject Address State

Age units at case investigation

Country of Birth

Time in U.S.

Date entered U.S.

Travel or Live Outside U.S.

Country of Exposure or Country Where  
Disease was Acquired

Note: use exposure or acquired consistently  
across variables

Subject's Sex

Race Category

Ethnic Group Code  
Country of Usual Residence

Earliest Date Reported to County  
Earliest Date Reported to State  
Diagnosis Date

Date of Onset of symptoms

Date sample collected  
Date test performed  
Type of test utilized to identify case  
Test Result  
Hospitalized  
Did patient expire?  
Current antimicrobial Treatment

Date current antimicrobial Treatment

Diabetes  
Chronic renal disease  
Chronic lung disease  
Liver disease or chronic alcohol abuse  
Thalassemia  
Non HIV-related immune suppression  
Military service  
Military service Date  
Laboratory exposure  
Laboratory exposure Date  
Contact with soil or water in melioidosis-  
endemic areas  
Contact with soil or water in melioidosis-  
endemic areas service Date  
Contact with someone with the same disease

Were you at any recent mass gathering?  
State or Local Public Health Laboratory/LRN  
POC- Name  
State or Local Public Health Laboratory/LRN  
POC- Phone number  
State or Local Public Health Lab/LRN POC  
Email Address  
State or Local Public Health Lab/LRN POC-  
Affiliation

Case origin/type  
Country of travel destination  
International Region  
Dates of International Travel  
Contact with soil or water in International travel destination  
Specific location of exposure for International Travel  
Other close contacts with same soil/water exposures (International Travel)  
Number of close contacts (International Travel)  
Relationship (International Travel)  
Significant weather or environmental events during this visit (International Travel)

Specific weather or environmental events (International Travel)

Contact with soil or water in melioidosis-endemic areas

Contact with soil or water in melioidosis-endemic areas service Date

Travel within U.S. but >50 miles from residence

State

City/town

Dates of Travel

Contact with soil or water in travel destination

Specific location of exposure

Other close contacts with same soil/water exposures

Number of close contacts

Relationship

Significant weather or environmental events during this visit

Specific weather or environmental events  
Travel (in the last 10 years)

Country of travel destination (in the last 10 years)

Region of travel in last 10 years

Dates of Travel (in the last 10 years)

Contact with soil or water in travel destination (in the last 10 years)

Specific location of exposure (in the last 10 years)

Other close contacts with same soil/water exposures (International Travel)

Number of close contacts (International Travel)

Relationship (International Travel)

Significant weather or environmental events during this visit (International Travel)

Specific weather or environmental events (International Travel)

Specify other or abscess for "specimen source"

Date of LRN confirmation, if applicable

AST Request

Dates of Hospitalization

Pneumonia/pleural effusion

Skin/soft tissue infections

Genitourinary infection

Neurologic infection

Pericardial effusion

Bone or joint infection

Internal abscesses

Select or specify location of abscesses

Additional notes describing abscesses

Septic Shock

Bacteremia

Date antimicrobial Treatment ended

Liver disease

Excess alcohol abuse

Chronic granulomatous disease

Malignancy

Systemic lupus erythematosus

Prior splenectomy

Immunosuppressing drugs

Other immunocompromising condition

Patient's Occupation

Recreational Gardener

Is this case part of a cluster?

Exposure to Iguanas

Type of Iguana

Type of exposure

If owned, how acquired

Location of purchase or where acquired

## Exposure to Pet Fish

Type of pet fish

Type of exposure

If owned, how acquired

Location of purchase or where acquired

## Exposure to Aquatic Plants

Type of aquatic plant

Type of exposure

If owned, how acquired

Location of purchase or where acquired

## Exposure to Other Animals

Type of "Other Animal"

Type of exposure

If owned, how acquired

Location of purchase or where acquired

## Laboratory exposures identified

Name of Facility (Exposures)

City/town (Exposures)

State (Exposures)

Number of laboratorians exposed

High Risk

Low Risk

Minimal Risk

Date of Exposure

Risk Factors

Laboratory Activity

Risk Category

Serologic Monitoring

Received post-exposure prophylaxis

Reported Symptoms (lab exposures)

Onset Date (lab exposure)

Describe Symptoms

Physician Name

Physician Phone

Patient Case Status

Microorganism Identified in Isolate

Underlying Condition(s)

Immunocompromised Associated Condition  
or Treatment

Continents Visited

Most recent year visited

Visited or Lived in States

Travel

Travel Outside USA Prior to Illness Onset  
within Program Specific Timeframe

Activity Type

Severe Weather Location

Event Notes

Signs and Symptoms Indicator

Treatment Drug Indicator

Reason Medication Not Completed

Antimicrobials Not Taken or Discontinued

Disease Outcome Type

Specimen Source Site

Specimen Sent to CDC

## Description

States use this field to link NEDSS investigations back to their own state investigations.

Date the case was first reported to the CDC

Status of the notification.

Condition or event that constitutes the reason the notification is being sent

Status of the case/event as suspect, probable, confirmed, or not a case per CSTE/CDC/surveillance case definitions.

MMWR Week for which case information is to be counted for MMWR publication.

MMWR Year (YYYY) for which case information is to be counted for MMWR publication.

State reporting the notification.

County reporting the notification.

National jurisdiction reporting the notification to CDC.

Type of facility or provider associated with the source of information sent to Public Health.

ZIP Code of the reporting source for this case.

Earliest date the case was reported to the public health department whether at the local, county, or state public health level.

Name of the person who is reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Phone Number of the person who is reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Job title / description of the person reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

Affiliated Facility of the person reporting the case to the CDC. This is the person that CDC should contract in a state if there are questions regarding this case notification.

County of residence of the subject

State of residence of the subject

Subject age units at time of case investigation

Country of Birth

Length of time this subject has been living in the U.S. (if born out of the U.S.)

Date entered U.S. in YYYYMM format (if born out of the U.S.)

Did the subject travel or live outside the U.S.A.?

Indicates the country in which the disease was potentially acquired.

Subject's current sex

Field containing one or more codes that broadly refer to the subject's race(s).

Based on the self-identity of the subject as Hispanic or Latino  
Where does the person usually\* live (defined as their residence)

\*For the definition of 'usual residence' refer to CSTE position statement # 11-SI-04 titled "Revised Guidelines for Determining Residency for Disease Reporting" at <http://www.cste.org/ps2011/11-SI-04.pdf> .

Earliest date reported to county public health system

Earliest date reported to state public health system

Earliest date of diagnosis (clinical or laboratory) of condition being reported to public health system

Date of the beginning of the illness. Reported date of the onset of symptoms of the condition being reported to the public health system

Provide date test was performed in YYYYMM format

Provide date test was performed in YYYYMM format

Indicate the type of test performed to confirm case

Epidemiologic interpretation of the results of the tests performed for this case

Indicate whether subject was or is currently hospitalized due to this illness

Indicate whether subject died of this illness

Indicate all antimicrobial drugs used to treat subject

Indicate the date antimicrobial treatment started

Does subject have diabetes?

Does subject have chronic renal disease?

Does subject have chronic lung disease?

Does subject have liver disease or chronic alcohol abuse?

Does subject have thalassemia?

Does subject have non HIV-related immune suppression?

Has subject ever served overseas in in the military?

If yes, date of service in YYYYMM format.

Was subject ever exposed to burkholderia through lab work?

If yes, date of exposure in YYYYMM format.

Has subject ever been in contact with soil or water in melioidosis-endemic areas?

If yes, date of contact in YYYYMM format.

Did subject have contact with someone diagnosed with melioidosis?

Was subject present at any recent mass gathering?

Name of the laboratory person who is the lab POC for this investigation

Phone number of the laboratory person who is the lab POC for this investigation

Email address of person who is reporting cases to CDC

Affiliated Facility of the state LRN/lab POC

Is this a human or animal case?

Choose a country for each destination

Enter region (list multiple if applicable)

Enter dates of travel (multiple if applicable)

Was the subject contact with soil or water during this visit?

If yes to Question above, indicate specific location of exposure

If yes to Question above, indicate whether other close contacts also had the same soil/water exposure

If yes to Question above, list the total number of close contacts

If yes to Question above, select relationship to subject (select all that apply)

Were there any significant weather or environmental events during this visit?

If yes to Question above, select all weather/environmental events

Has subject ever been in contact with soil or water in melioidosis-endemic areas?

If yes, date of contact in YYYYMM format.

Did the subject travel 50 miles or more outside his or her normal residence but within the U.S. 30 days prior to onset?

Choose a state each destination

Please indicate city/town (list multiple if applicable)

Enter dates of travel

Was the subject contact with soil or water during this visits?

If yes to Question above, indicate specific location of exposure

If yes to Question above, were there other close contacts also had the same soil/water exposure

If yes to Question above, list the total number of close contacts

If yes to Question above, select relationship to subject (select all that apply)

Were there any significant weather or environmental events during this visit?

If yes to Question above, select all weather/environmental events

In the 10 years before symptoms onset, did the patient travel outside of the continental U.S. or to an area in the U.S. where the endemicity is possible

Choose a country for each destination

Enter region (list multiple if applicable)

Enter dates of travel

Was the subject contact with soil or water during this visit?

If yes to Question above, indicate specific location of exposure

If yes to Question above, indicate whether other close contacts also had the same soil/water exposure

If yes to Question above list the total number of close contacts

If yes to Question above, select relationship to subject (select all that apply)

Were there any significant weather or environmental events during this visit?

If yes to Question above, select all weather/environmental events

If abscess or other specimen selected, please specify

Enter Date of Confirmation by LRN

Is the jurisdiction requesting AST on the isolate

Give reporting jurisdiction ability to enter multiple hospitalizations if needed

Did the subject have pneumonia/pleural effusion

Did the subject have skin/soft tissue infection

Did the subject have genitourinary infection

Did the subject have neurologic infection

Did the subject have pericardial effusion

Did the subject have bone/joint infection

Did the patient have internal abscesses

If yes, for internal abscesses, please select all that apply

If yes for internal abscesses, additional notes (number, location of abscesses)

Did the subject have septic shock

Did the subject have bacteremia

Indicate the date antimicrobial treatment ended

Does subject have liver disease

Does subject have history chronic alcohol abuse?

Does the subject have chronic granulomatous disease?

Does the subject have malignancy?

Does the subject have systemic lupus erythematosus?

Does the subject have a history of prior splenectomy

Is the subject on any immunosuppressing medication

Does the patient have any other immunocompromising conditions

What is the patient's occupation

Is the patient a recreational gardener?

Is this case part of a cluster?

In the 30 days prior to symptoms onset did the patient own or have direct contact with an iguana?

Indicate type of iguana if yes to previous question

Indicate type of exposure if yes to exposure to iguana

If owned an iguana, indicate how case patient acquired

Location of purchase/where acquired (name of river, lake, park, or location of pet store, for example)

In the 30 days prior to symptoms onset did the patient own or have direct contact with pet fish?

Indicate type of pet fish if yes to previous question

Indicate type of exposure if yes to exposure to pet fish

If owned a pet fish, indicate how case patient acquired

Location of purchase/where acquired (name of river, lake, park, or location of pet store, for example)

In the 30 days prior to symptoms onset did the patient own or have direct contact with aquatic plants?

Indicate type of aquatic plant if yes to previous question

Indicate type of exposure if yes to exposure to aquatic plants

If owned aquatic plant, indicate how case patient acquired

Location of purchase/where acquired (name of river, lake, park, or location of pet store, for example)

In the 30 days prior to symptoms onset did the patient own or have direct contact with other animals

Indicate type of other animal if yes to previous question

Indicate type of exposure if yes to exposure to "other animal"

If owned "other animal", indicate how case patient acquired

Location of purchase/where acquired (name of river, lake, park, or location of pet store, for example)

Were potential laboratory exposures identified in this investigation

Name of facility/hospital where exposures were identified

City of facility where exposures were identified

State where the facility where the exposures were identified

Total number of laboratory personnel exposures

Number of laboratory personnel with high-risk exposures

Number of laboratory personnel with low-risk exposures

Number of laboratory personnel with minimal exposures

For each laboratory personnel, date of exposures

Does the laboratory personnel have risk factors for melioidosis

Select activity that resulted in exposure

For each laboratory personnel and each activity, select risk category

Did the laboratory personnel undergo serologic monitoring

Did the laboratory personnel receive post-exposure prophylaxis

Did the laboratory personnel report symptoms within 21 days of exposure

If the laboratory personnel reported symptoms, please provide onset date

If the laboratory personnel reported symptoms, describe

Name of the physician or clinician who diagnosed and/or treated the patient

Phone number of the patient's clinician/provider of care

Indicate the patient's case status

Pathogen/Organism Identified in Isolate

Listing of underlying causes or prior illnesses

If the subject was immunocompromised, what was the associated immunocompromising condition or treatment?

Select all continents where patient has visited or lived in their lifetime

Most recent year visited (continents)

Has the patient EVER visited or lived in any of the following US states in their lifetime?

In the 30 days prior to illness onset, did the patient travel 50 miles or more from their normal residence?

Did the subject travel internationally in the 30 days prior to illness onset?

What activities led to the indicated environmental or animal exposure(s)?

Specify the location where severe weather occurred (e.g., home, work)

Notes related to event exposure

Indicator for associated signs and symptoms

Did the subject receive antimicrobials for this illness or following an exposure?

Reason full course of antimicrobials was not completed

Did the patient complete the course of antimicrobials received?

Patient's status or outcome for this condition

If specimen type is tissue, indicate the anatomical source (e.g., lung, kidney)

Was specimen(s) sent to CDC for testing?

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_ResultStatus\_NETSS  
PHVS\_NotifiableEvent\_Disease\_Condition\_CDC\_NNDSS  
PHVS\_CaseClassStatus\_NND

PHVS\_State\_FIPS\_5-2  
PHVS\_County\_FIPS\_6-4  
PHVS\_NationalReportingJurisdiction\_NND  
PHVS\_ReportingSourceType\_NND

PHVS\_County\_FIPS\_6-4  
PHVS\_State\_FIPS\_5-2  
PHVS\_AgeUnit\_UCUM\_NETSS  
PHVS\_CountryofBirth\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_Country\_ISO\_3166-1

PHVS\_Sex\_MFU  
PHVS\_RaceCategory\_CDC

PHVS\_EthnicityGroup\_CDC\_Unk  
PHVS\_CountryofBirth\_CDC

PHVS\_LabTestInterpretation\_melioidosis  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_MedicationTreatment\_Melioidosis

PHVS\_MedicationTreatment\_Date\_Melioidosis

PHVS\_YesNoUnknown\_CDC  
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PHVS\_Country\_ISO\_3166-1

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PHVS\_YesNoUnknown\_CDC

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PHVS\_YesNoUnknown\_CDC

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PHVS\_State\_FIPS\_5-2

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PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

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PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_ReasonMedicationNotCompleted\_BSP

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PHVS\_YesNoUnknown\_CDC



CDC Priority (New)

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| Label/Short Name                               | Description                                                                                                                                                                                                                                                                                                                    |
|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MIS ID                                         | Multisystem inflammatory syndrome identifier.                                                                                                                                                                                                                                                                                  |
| Health Department ID                           | Health Department identifier.                                                                                                                                                                                                                                                                                                  |
| NCOV ID                                        | COVID-19 identifier (if available)                                                                                                                                                                                                                                                                                             |
| Abstractor name                                | Name of person compiling medical records and/or interviews.                                                                                                                                                                                                                                                                    |
| Date of abstraction                            | Date of abstraction                                                                                                                                                                                                                                                                                                            |
| Temperature if fever                           | Fever >38.0°C for ≥24 hours, or report of subjective fever lasting ≥24 hours                                                                                                                                                                                                                                                   |
| Inflammation laboratory markers                | Laboratory markers of inflammation (including, but not limited to one or more; an elevated C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), fibrinogen, procalcitonin, d-dimer, ferritin, lactic acid dehydrogenase (LDH), or interleukin 6 (IL-6), elevated neutrophils, reduced lymphocytes and low albumin), |
| Signs and symptoms                             | Evidence of clinically severe illness requiring hospitalization, with multisystem (>2) organ involvement.                                                                                                                                                                                                                      |
| Signs and symptoms indicator                   | Indicator for associated sign and symptom                                                                                                                                                                                                                                                                                      |
| No alternative plausible diagnosis             | Is there no alternative plausible diagnosis?                                                                                                                                                                                                                                                                                   |
| SARS-COV-2 test                                | Positive for current or recent SARS-COV-2 infection (select all applicable tests)                                                                                                                                                                                                                                              |
| Symptom onset within 4 weeks of exposure       | COVID-19 exposure within the 4 weeks prior to the onset of symptoms                                                                                                                                                                                                                                                            |
| Date of symptom onset                          | If yes, date of first exposure within the 4 weeks prior                                                                                                                                                                                                                                                                        |
| Height                                         | Height specified in inches                                                                                                                                                                                                                                                                                                     |
| Weight                                         | Weight in pounds                                                                                                                                                                                                                                                                                                               |
| Body Mass Index                                | Body Mass Index                                                                                                                                                                                                                                                                                                                |
| Patient Epidemiological Risk Factors           | Underlying medical conditions or risk behaviors for the case patient.                                                                                                                                                                                                                                                          |
| Patient Epidemiological Risk Factors Indicator | Provide a response for each value in the risk factors value set.                                                                                                                                                                                                                                                               |
| Type of complication                           | Complications associated with the illness being reported                                                                                                                                                                                                                                                                       |
| Type of complication indicator                 | Provide a response for each complication.                                                                                                                                                                                                                                                                                      |
| ICU Admission Date                             | If admitted to the ICU, ICU admission date                                                                                                                                                                                                                                                                                     |
| Days in ICU                                    | Number of days in ICU                                                                                                                                                                                                                                                                                                          |
| Patient outcome                                | Patient outcome                                                                                                                                                                                                                                                                                                                |
| Preceding COVID-like illness                   | Did the patient have preceding COVID-like illness?                                                                                                                                                                                                                                                                             |
| Date of onset of preceding COVID-like illness  | If yes, date of onset of preceding illness                                                                                                                                                                                                                                                                                     |

|                                                 |                                                                                                |
|-------------------------------------------------|------------------------------------------------------------------------------------------------|
| Fever                                           | Fever $\geq 38.0^{\circ}\text{C}$                                                              |
| Date of fever onset                             | Date of fever onset                                                                            |
| Highest temperature                             | Highest temperature $^{\circ}\text{C}$                                                         |
| Number of days febrile                          | Number of days febrile                                                                         |
| Clinical finding                                | Clinical finding                                                                               |
| Clinical finding indicator                      | Provide a response for each clinical finding.                                                  |
| Treatment Type                                  | Listing of treatment or medical intervention the subject received for this illness             |
| Treatment type indicator                        | Provide a response for each treatment type.                                                    |
| Vasoactive medications                          | Specify vasoactive medications                                                                 |
| Immune modulators                               | Specify immune modulators treatment                                                            |
| Antiplatelets                                   | Specify antiplatelets treatment                                                                |
| Anticoagulation                                 | Specify anticoagulation treatment                                                              |
| Echocardiogram                                  | Select any echocardiogram that apply.                                                          |
| Max coronary artery Z-score                     | If coronary artery aneurysms, state max coronary artery Z-score.                               |
| Cardiac dysfunction                             | If cardiac ventricular dysfunction, specify type.                                              |
| Mitral regurgitation                            | Specify type of mitral regurgitation.                                                          |
| Date of coronary artery aneurysm                | Date of first test showing coronary artery aneurysm or dilatation.                             |
| Abdominal imaging type                          | Type of abdominal imaging (ultrasound, CT)                                                     |
| Chest imaging type                              | Type of chest imaging (chest x-ray, CT)                                                        |
| MIS Inclusion                                   | Did the patient meet all inclusion criteria associated with MIS illness case definition        |
| MIS Inclusion Criteria                          | Inclusion criteria associated with the illness being reported                                  |
| MIS Inclusion Criteria indicator                | Indicator for associated inclusion criteria                                                    |
| Patient outcome date                            | Date of hospital discharge or death                                                            |
| Medical history                                 | Does the patient have a history of the following illnesses prior to developing MIS-C symptoms? |
| Medical history indicator                       | Indicator for associated medical history diagnosis                                             |
| Date of medical history                         | Date of past medical history diagnosis                                                         |
| Imaging Study                                   | Listing of imaging studies the subject received for this illness                               |
| Imaging Study indicator                         | Provide a response for normal or abnormal results for each imaging study received              |
| Left ventricular ejection fraction (LVEF) level | Specify left ventricular ejection fraction (LVEF)                                              |

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

N/A

N/A

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TBD

TBD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

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PHVS\_YesNoUnknown\_CDC

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PHVS\_YesNoUnknown\_CDC

MIS Inclusion (MIS)  
PHVS\_YesNoUnknown\_CDC

N/A  
Patient history (MIS)

Patient history (MIS)  
N/A  
Imaging Studies  
Normal, Abnormal, Not Done

1:≥55%, 2: 50-54% 3: <50%



CDC Priority (New)

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| Label/Short Name                               | Description                                                                                                                                                                    |
|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Tribal Residence                               | If you reside in a Tribal Area, please specify                                                                                                                                 |
| Tribal Name                                    | If the selected race is American Indian or Alaska Native, what is the tribal affiliation?                                                                                      |
| Gender Identity                                | Do you currently describe yourself as male, female, or transgender?                                                                                                            |
| Sexual Orientation                             | Patient identified sexual orientation (i.e., an individual's physical and/or emotional attraction to another individual of the same gender, opposite gender, or both genders). |
| Birth Sex                                      | What sex were you assigned at birth, on your original birth certificate?                                                                                                       |
| Reason Vaccine Administered                    | Reason individual received a vaccine against this condition                                                                                                                    |
| Sexual Contact                                 | Did you engage in any sex and/or close intimate contact before your first symptom appeared?                                                                                    |
| Sex with Male Partners                         | Sex with male partners?                                                                                                                                                        |
| Number of Male Sexual Partners                 | Number of male partners or description if no number is provided                                                                                                                |
| Numerical Range of Male Partners               | If individual is unable to specify, provide a range of options for the number of male partners                                                                                 |
| Sex with Female Partners                       | Sex with female partners?                                                                                                                                                      |
| Number of Female Sexual Partners               | Number of female partners or description if no number is provided                                                                                                              |
| Numerical Range of Female Partners             | If individual is unable to specify, provide a range of options for the number of female partners                                                                               |
| Sex with Transgender Female Partners           | Sex with transgender female partners?                                                                                                                                          |
| Number of Transgender Female Partners          | Number of transgender female partners or description if no number is provided                                                                                                  |
| Numerical Range of Female Transgender Partners | If individual is unable to specify, provide a range of options for the number of transgender female partners                                                                   |
| Sex with Transgender Male Partners             | Sex with transgender male partners?                                                                                                                                            |
| Number of Transgender Male Partners            | Number of transgender male partners or description if no number is provided                                                                                                    |
| Numerical Range of Transgender Male Partners   | If individual is unable to specify, provide a range of options for the number of transgender male partners                                                                     |
| Sex with Other Gender Identity Partners        | Sex with other gender identity partners?                                                                                                                                       |
| Number of Other Gender Identity Partners       | Number of other gender identity partners or description if no number is provided                                                                                               |

|                                                                             |                                                                                                                                                                  |
|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Numerical Range of Other Identity Gender Partners                           | If individual is unable to specify, provide a range of options for the number of other gender identity partners                                                  |
| Epi Linked                                                                  | Specify if this case is epidemiologically linked to another confirmed or probable case                                                                           |
| CDC Event Case ID                                                           | This ID is used to track information about the case-patient in CDC data systems and must be provided on all forms or specimens related to this individual        |
| Linked Case Number                                                          | Provide State assigned Case ID                                                                                                                                   |
| Contact Type                                                                | Type of contact                                                                                                                                                  |
| Specify Other Contact Type                                                  | Other contact type                                                                                                                                               |
| Did The Case Travel Domestically Prior To Illness Onset?                    | Did you spend time (within the US) outside your home state or territory during the [time period] before your first symptom appeared (also called symptom onset)? |
| Travel State                                                                | State traveled to                                                                                                                                                |
| Date Of Departure From Travel Destination                                   | Date of departure (MM/DD/YYYY)                                                                                                                                   |
| Date Of Arrival To Travel Destination                                       | Date of return (MM/DD/YYYY)                                                                                                                                      |
| Sexual Contact During Domestic Travel                                       | Did you have intimate or sexual contact with new partners on domestic trip?                                                                                      |
| Domestic Travel Comment                                                     | Any additional comments on travel within the US that may be important                                                                                            |
| Travel Outside USA Prior To Illness Onset Within Program Specific Timeframe | Did you spend time in a country outside the US during the [time period] before your first symptom appeared (also called symptom onset)?                          |
| International Destination(s) of Recent Travel                               | Country traveled to                                                                                                                                              |
| Sexual Contact During International Travel                                  | Did you have any intimate or sexual contact with new partners on international trip?                                                                             |
| International Travel Comment                                                | Any additional comments on travel outside the US that may be important?                                                                                          |
| Case Patient a Healthcare Worker                                            | Is this individual a health care worker who was exposed at work?                                                                                                 |
| Location of Exposure                                                        | Please provide the suspect location of exposure                                                                                                                  |
| Exposure Comment                                                            | Please provide any additional details on the location of exposure (e.g., health care setting, large gathering, private party)                                    |
| Number of Household Contacts                                                | Please provide the number of identified contacts this case may have exposed (either named or anonymous)                                                          |
| Signs and Symptoms                                                          | Signs and symptoms associated with the illness being reported                                                                                                    |
| Signs and Symptoms Indicator                                                | Indicator for associated sign and symptom                                                                                                                        |
| Skin Lesion(s) (disorder)                                                   | Did you have a rash during the course of your illness?                                                                                                           |

|                                          |                                                                                                                                          |
|------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| Rash Onset Date                          | If yes, what was the date of rash onset (i.e., the date the rash first appeared)?                                                        |
| Body Region(s) of Rash                   | If yes, where on your body is the rash? (choose all that apply)                                                                          |
| Ocular Manifestations                    | Any evidence of ocular involvement (ocular lesions, keratitis, conjunctivitis, eyelid lesions)?                                          |
| Co-infection                             | Has this individual been diagnosed with any acute infections other than [condition] during this current illness/or within [time period]? |
| Co-infection Type                        | Specify other co-infections                                                                                                              |
| HIV Status                               | What is the individual's HIV status?                                                                                                     |
| HIV Viral Load Undetectable              | If HIV positive, was the individual's viral load undetectable when it was last checked?                                                  |
| Patient Immunocompromised                | Does the individual have any known immunocompromising conditions (excluding HIV) or take immunosuppressive medications?                  |
| Immunocompromised Condition or Treatment | Describe the associated immunocompromising condition or treatment                                                                        |
| Reason for Hospitalization               | Reason for the hospitalization? (choose all that apply)                                                                                  |
| Receiving HIV Pre-exposure Prophylaxis   | Is the individual currently receiving HIV pre-exposure prophylaxis?                                                                      |
| Currently Breastfeeding                  | Are you currently breastfeeding?                                                                                                         |
| Household pets                           | Do any pets live in your household?                                                                                                      |
| Type of animal(s)                        | Which type of animal(s) in household? (select all that apply)                                                                            |
| Other pet(s)                             | Please specify other pet(s)                                                                                                              |
| Vaccine Route of Administration          | The route of administration of the vaccine                                                                                               |

| Value Set Code. Search in PHIN VADS using the following link<br>( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) | CDC Priority (Legacy) | CDC Priority (New) |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|--------------------|
| TBD                                                                                                                                                                               |                       | 2                  |
| PHVS_TribeName_NND                                                                                                                                                                |                       | 3                  |
| PHVS_GenderIdentity_USCDI                                                                                                                                                         |                       | 1                  |
| PHVS_SexualOrientation_USCDI                                                                                                                                                      |                       | 2                  |
| PHVS_Sex_MFU                                                                                                                                                                      |                       | 1                  |
| TBD                                                                                                                                                                               |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             |                       | 2                  |
| N/A                                                                                                                                                                               |                       | 2                  |
| TBD                                                                                                                                                                               |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             |                       | 2                  |
| N/A                                                                                                                                                                               |                       | 2                  |
| TBD                                                                                                                                                                               |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             |                       | 2                  |
| N/A                                                                                                                                                                               |                       | 2                  |
| TBD                                                                                                                                                                               |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             |                       | 2                  |
| N/A                                                                                                                                                                               |                       | 2                  |
| TBD                                                                                                                                                                               |                       | 2                  |
| PHVS_YesNoUnknown_CDC                                                                                                                                                             |                       | 2                  |
| N/A                                                                                                                                                                               |                       | 2                  |

|                         |  |   |
|-------------------------|--|---|
| TBD                     |  | 2 |
| PHVS_YesNoUnknown_CDC   |  | 1 |
| N/A                     |  | 3 |
| N/A                     |  | 3 |
| TBD                     |  | 1 |
| N/A                     |  | 1 |
| PHVS_YesNoUnknown_CDC   |  | 3 |
| PHVS_State_FIPS_5-2     |  | 3 |
| N/A                     |  | 3 |
| N/A                     |  | 3 |
| PHVS_YesNoUnknown_CDC   |  | 3 |
| N/A                     |  | 3 |
| PHVS_YesNoUnknown_CDC   |  | 3 |
| PHVS_Country_ISO_3166-1 |  | 3 |
| PHVS_YesNoUnknown_CDC   |  | 3 |
| N/A                     |  | 3 |
| PHVS_YesNoUnknown_CDC   |  | 1 |
| TBD                     |  | 1 |
| N/A                     |  | 1 |
| N/A                     |  | 2 |
| TBD                     |  | 3 |
| PHVS_YesNoUnknown_CDC   |  | 3 |
| PHVS_YesNoUnknown_CDC   |  | 3 |

|                                |  |   |
|--------------------------------|--|---|
| N/A                            |  | 3 |
| TBD                            |  | 3 |
| TBD                            |  | 3 |
| PHVS_YesNoUnknown_CDC          |  | 3 |
| TBD                            |  | 3 |
| PHVS_HIVStatus_STD             |  | 1 |
| PHVS_YesNoUnknown_CDC          |  | 2 |
| PHVS_YesNoUnknown_CDC          |  | 1 |
| TBD                            |  | 1 |
| TBD                            |  | 2 |
| PHVS_YesNoUnknown_CDC          |  | 2 |
| PHVS_YesNoUnknown_CDC          |  | 2 |
| PHVS_YesNoUnknown_CDC          |  | 2 |
| TBD                            |  | 2 |
| N/A                            |  | 2 |
| PHVS_RouteOfAdministration_IIS |  | 2 |

Label/Short Name

Did the subject have a fever?

Date of Fever Onset

Highest Measured Temperature

Temperature Units

Parotitis (opposite second (2nd)  
molars)? (Symptom)

Unilateral or Bilateral Parotitis  
(Symptom)

Jaw Pain (Symptom)

Salivary Gland Swelling Onset Date

Salivary Gland Swelling Duration

Salivary Gland Swelling Duration  
Units

Submandibular Swelling (Symptom)

Sublingual Swelling (Symptom)

Import Status

International Destination(s) of recent  
travel

Date of return from travel

Encephalitis (Complication)

Meningitis (Complication)

Deafness (Complication)

Type of Deafness

Orchitis (Complication)

Other Complication

Specify Other Complication

Was laboratory testing done for  
mumps?

Test Type

Test Result

Numeric Test Result

Numeric Test Result Units

Sample Analyzed Date

Test Method

Date Collected

Specimen Source

Were the specimens sent to CDC for  
genotyping (molecular typing)?

Date sent for genotyping

Transmission Setting

Were Age and Setting Verified?

Source of Infection

Case Class by Source

Is this Case Epi-Linked to Another  
Confirmed or Probable Case?

Did the subject ever receive a  
disease-containing vaccine?

If no, reason subject did not receive  
a disease-containing vaccine

Number of doses received ON or  
AFTER first birthday

Vaccine History Comments

Vaccine Administered

Vaccine Manufacturer

Vaccine Lot Number

Vaccine Administered Date

US Acquired

Length of time in the US

Length of Time in the U.S. units

Patient Address City

Case Investigation Status Code

Detection Method

Transmission Setting, Other

Laboratory Confirmed

Specimen sent to CDC

Type of testing at CDC

Type of testing at CDC, other

Date specimen sent to CDC

VPD Lab Message Patient Identifier

VPD Lab Message Observation  
Identifier

VPD Lab Message Observation Value

Other Lab Test

Performing Laboratory Type

Other (Performing Laboratory Type)

Date of last dose prior to illness  
onset

Vaccination doses prior to onset

Vaccinated per ACIP  
recommendations

Reason not vaccinated per ACIP  
recommendations

Reason not vaccinated per ACIP,  
Other

Vaccine Administered Product Type,  
Other

Vaccine Product Manufacturer,  
Other

NDC Brand Name/Bar Code  
information

Vaccination Record ID

Reason immunization not given,  
regardless of the schedule used

## Description

Did the subject have a measured temperature greater than two degrees above normal?

Date of fever onset

What was the subject's highest measured temperature during this illness?

The units of measure of the highest measured temperature. This would be either Fahrenheit or Celsius.

Did the subject have parotitis as a symptom of this illness?

Indicates if the parotitis is unilateral or bilateral

Did the subject have jaw pain as a symptom of this illness?

Date of subject's salivary gland swelling (including parotitis) onset.

The length of time that the subject exhibited swelling of the salivary gland.

The length of time units that the subject exhibited swelling of the salivary gland

Did the subject have submandibular swelling as a symptom of this illness?

Did the subject have sublingual swelling as a symptom of this illness?

Did symptom onset occur within 12-25 days of entering the U.S., following any travel or living outside the U.S.?

List any international destinations of recent travel

Date the subject returned from all travel

Did the subject develop encephalitis as a complication of this illness?

Did the subject develop meningitis as a complication of this illness?

Did the subject become deaf as a complication of this illness?

Was the type of deafness permanent or temporary?

Did the subject develop orchitis as a complication of this illness?

Did the subject develop an other condition as a complication of this illness?

Please specify the other complication the subject developed, during or as a result of this illness.

Was laboratory testing done to confirm a diagnosis of mumps?

Epidemiologic interpretation of the type of test(s) performed for this case.

Epidemiologic interpretation of the results of the tests performed for this case

Numeric quantitative result of the test(s) performed for this case

Numeric quantitative result unit of the test(s) performed for this case

The date the specimen/isolate was tested.

The technique or method used to perform the test and obtain the test results.

Date of specimen collection

The medium from which the specimen originated

Were clinical specimens sent to CDC laboratories for genotyping (molecular typing)?

The date the specimens were sent to the CDC laboratories for genotyping

What was the transmission setting where the mumps was acquired?

Does the age of the case match or make sense for the transmission setting listed (e.g., a subject aged 80 probably would not have a transmission setting of child day care center)?

What was the source of the mumps infection?

If this is a case acquired in the U.S., how should the case be classified by source?

Specify if this case is Epidemiologically-linked to another confirmed or probable case of mumps?

Did the subject ever receive a mumps-containing vaccine?

Specifies reason the subject did not receive a mumps-containing vaccine

The number of measles-containing vaccine doses the subject received on or after their first birthday

Comments about the subject's vaccination history.

The type of vaccine administered.

Manufacturer of the vaccine.

The vaccine lot number of the vaccine administered.

The date that the vaccine was administered.

Sub-classification of disease or condition acquired in the US

Length of time in the US, from NBS MM

Length of time in the US Units

Patient address city, from NBS MM

Case Investigation Status Code, from NBS MM

Detection Method, from NBS MM

If Other, Specify Transmission Setting

Was the case laboratory confirmed?

Was a specimen sent to CDC for testing?

What type of testing was done at CDC for this subject?

If other, specify testing done at CDC

Date specimen sent to CDC

VPD Lab Message Patient Identifier

VPD Lab Message Observation Identifier

VPD Lab Message Observation Value

If other, specify lab test

Performing laboratory type

If other, specify performing laboratory type

Date of last disease-containing vaccination dose prior to illness onset

Number of disease-containing vaccination doses prior to illness onset

Was subject vaccinated as recommended by ACIP?

Reason subject not vaccinated as recommended by ACIP

If other, specify reason not vaccinated per ACIP

If other, specify type of vaccine administered

If other, specify vaccine manufacturer

NDC from the vaccine's bar code. With the NDC code, vaccine brand name and manufacturer can be obtained.

Vaccination Record ID, from NBS MM

Reason subject was not vaccinated, regardless of the immunization schedule used

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

PHVS\_TemperatureUnit\_UCUM

PHVS\_YesNoUnknown\_CDC

PHVS\_ParotitisLaterality\_Mumps

PHVS\_YesNoUnknown\_CDC

PHVS\_AgeUnit\_UCUM

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_Country\_ISO\_3166-1

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_DeafnessType\_Mumps

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_LabTestProcedure\_Mumps

PHVS\_LabTestInterpretation\_VPD

PHVS\_UnitsOfMeasure\_CDC

PHVS\_LabTestMethods\_CDC

PHVS\_SpecimenSource\_Mumps

PHVS\_YesNoUnknown\_CDC

PHVS\_TransmissionSetting\_NND

PHVS\_YesNoUnknown\_CDC

PHVS\_CaseClassificationExposureSource\_NND  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_VaccineNotGivenReasons\_CDC

PHVS\_VaccinesAdministeredCVX\_CDC\_NIP  
PHVS\_ManufacturersOfVaccinesMVX\_CDC\_NIP

PHVS\_CaseClassificationExposureSource\_NND

Label/Short Name

DAYCARE  
FACNAME  
NURSHOME  
NHNAME  
SYNDRM  
SPECSYN  
SPECIES  
OTHBUG1  
STERSITE  
OTHSTER  
DATE  
NONSTER  
UNDERCOND  
COND  
OTHMALIG  
OTHORGAN  
OTHILL  
OTHOTHSPC  
Specify Internal Body Site  
Other Prior Illness 2  
Other Prior Illness 3  
Other Nonsterile Site  
INSURANCE  
INSURANCEOTH  
WEIGHTLB  
WEIGHTOZ  
WEIGHTKG  
HEIGHTFT  
HEIGHTIN  
HEIGHTCM  
WEIGHTUNK  
HEIGHTUNK  
SEROGROUP  
OTHSERO  
COLLEGE  
  
CASEID  
OTHSTRST  
OTHID  
SCHOOLYR  
STUDTYPE  
HOUSE  
OTHHOUSE  
SCHOOLNM  
POLYVAC

SECCASE  
SECCASETY  
OTHSECCASE  
NMSULFRES  
NMRIFARES  
DIAGDATE  
PCRSOURCE  
IHCSPEC1  
IHCSPEC2  
IHCSPEC3  
MENGVAC  
Bacterial Infection Syndrome  
Gestational Age  
Birth Weight  
Birth Weight Units  
Secondary Case  
Recurrent Disease with Same  
Pathogen

Previous State ID (Recurrent  
Case) Report Form Status  
Had Sex with a Male within the  
Past 12 Months  
Had Sex with a Female within  
the Past 12 Months  
Number of Male Sexual Partners

HIV Status  
Homeless  
Signs and Symptoms

Signs and Symptoms Indicator  
Eculizumab  
Illness Onset Age  
Illness Onset Age Units  
Residence  
Epi-Linked to a Laboratory-  
Confirmed Case  
ABCS Case  
ABCS State ID  
Laboratory Testing Performed  
Laboratory Confirmed  
Serogroup Method  
Test Manufacturer  
Lab Accession Number

Susceptibility Test  
Did the Subject Ever Receive a  
Vaccine Against This Disease  
Date of Last Dose Prior to Illness  
Onset  
Vaccination Doses Prior to Onset  
Vaccine History Comments  
Vaccine Name  
Age at Vaccination  
Age at Vaccination Units  
Vaccine History Information  
Source  
Vaccine Information Source  
Indicator  
Ravuzumab

## Description

If <6 years of age, is the patient in daycare?

Name of the daycare facility.

Does the patient reside in a nursing home or other chronic care facility?

Name of the nursing home or chronic care facility.

Types of infection that are caused by the organism. This is a multi-select field.

Other infection that is caused by the organism.

Bacterial species that was isolated from any normally sterile site.

Other bacterial species that was isolated from any normally sterile site.

Sterile sites from which the organism was isolated. This is a multi-select field.

Other sterile site from which the organism was isolated.

Date the first positive culture was obtained. (This is considered diagnosis date.)

Nonsterile sites from which the organism was isolated. This is a multi-select field.

Did the patient have any underlying conditions?

Underlying conditions that the subject has. This is a multi-select field.

Other malignancy that the subject had as an underlying condition.

Detail of the organ transplant that the subject had as an underlying condition.

Other prior illness that the subject had as an underlying condition.

Another Bacterial Species not listed in the Other Bacterial Species drop-down list.

Internal Body Site where the organism was located.

Other prior illness that the subject had as an underlying condition.

Other prior illness that the subject had as an underlying condition.

Other nonsterile site from which the organism was isolated.

Patient's type of insurance (multi-selection).

Patient's other type of insurance.

Weight of the patient in pounds.

Weight of the patient in ounces.

Weight of the patient in kilograms.

Height of the patient in feet.

Height of the patient in inches.

Height of the patient in centimeters.

Indicator that the weight of the patient is unknown.

Indicator that the height of the patient is unknown.

Serogroup of the culture.

Other serogroup of the culture.

Is patient currently attending college? This question is only applicable if the patient is 15-24 years of age.

How was the case identified?

Other sterile site from which species was isolated.

Other case identification method.

Patient's year in college. (freshman, sophomore, etc.)

Patient's status in college as defined by the university.

Patient's current living situation.

Other housing option.

Full name of the college or university the patient is currently attending.

Has patient received the polysaccharide meningococcal vaccine?

Is this case of *Neisseria meningitidis* a secondary case?

Type of secondary contact for a case of *Neisseria meningitidis*.

Other field available if the secondary case type selected is other.

*Neisseria meningitidis* resistance to Sulfa.

*Neisseria meningitidis* resistance to Rifampin.

Date the sample was collected for diagnostic testing if a culture was not done.

Specifies the PCR source for how the case was identified.

Specifies the first IHC specimen.

Specifies the second IHC specimen.

Specifies the third IHC specimen.

Specifies whether the patient has received a meningococcal vaccine.

Types of infection caused by organism

If patient <1 month of age, indicate gestational age (in weeks)

If patient <1 month of age, indicate birth weight (grams)

Birth Weight Units

Is this a secondary case?

Does this case have recurrent disease with the same pathogen? (For *Streptococcus pneumoniae*, the specimen from the current case must have been isolated 8 or more days after any previous case due to the same pathogen. For all other pathogens, the specimen from the current case must have been isolated 30 or more days after any previous case due to the same pathogen.)

StateID of 1st occurrence for this pathogen and person.

Case Report Form Status

Had sex with a male within the past 12 months?

Had sex with a female within the past 12 months?

In the 3 months prior to the onset of symptoms, number of male sex partners the person had?

Documented or self-reported HIV status at the time of event

Was the patient homeless at time of symptom onset?

Indicate what symptoms of interest the patient had during the course of the illness

Indicator for associated sign and symptom

Was the patient taking eculizumab/Soliris at the time of disease onset?

Illness onset age

Illness onset age units

Where was the patient a resident at time of initial culture?

Is this case epi-linked to a laboratory-confirmed case?

ABCs Case?

ABCS State ID

Was laboratory testing done to confirm the diagnosis?

Was the case laboratory confirmed?

Serogroup method

Test Manufacturer

Lab Accession Number (including CDC Lab ID)

Was any susceptibility data available?

Did the subject ever receive a vaccine against this disease?

Date of last vaccine dose against this disease prior to illness onset

Number of vaccine doses against this disease prior to illness onset

Vaccine History Comments

Vaccine Name

The persons age at the time the vaccine was given

The age units of the person at the time the vaccine was given

What sources were used for vaccination history?

Vaccination History Information Source Indicator

Was the patient taking Ravulizumab (Ultomiris) at the time of disease onset?

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

TBD

TBD  
TBD  
TBD

TBD  
PHVS\_YesNoUnknown\_CDC  
TBD

TBD

TBD

PHVS\_TrueFalse\_CDC  
PHVS\_TrueFalse\_CDC  
TBD

PHVS\_YesNoUnknown\_CDC  
TBD

TBD  
TBD  
TBD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
TBD

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

TBD

|                         |   |
|-------------------------|---|
| PHVS_InfectionType_RIBD | P |
| N/A                     | P |
| N/A                     | P |
| PHVS_WeightUnit_UCUM    | P |
| PHVS_YesNoUnknown_CDC   | P |
| PHVS_YesNoUnknown_CDC   | P |

|                      |   |
|----------------------|---|
| N/A                  | P |
| PHVS_FormStatus_RIBD | P |
| PHVS_YNRD_CDC        | P |

|               |   |
|---------------|---|
| PHVS_YNRD_CDC | P |
|---------------|---|

|     |   |
|-----|---|
| N/A | P |
|-----|---|

|                         |   |
|-------------------------|---|
| PHVS_HIVStatus_STD      | P |
| PHVS_YesNoUnknown_CDC   | P |
| PHVS_SignsSymptoms_RIBD | P |

|                             |   |
|-----------------------------|---|
| PHVS_YesNoUnknown_CDC       | P |
| PHVS_YesNoUnknown_CDC       | P |
| N/A                         | P |
| PHVS_AgeUnit_UCUM           | P |
| PHVS_ResidenceLocation_RIBD | P |
| PHVS_YesNoUnknown_CDC       | P |

|                           |   |
|---------------------------|---|
| PHVS_YesNoUnknown_CDC     | P |
| N/A                       | P |
| PHVS_YesNoUnknown_CDC     | P |
| PHVS_YesNoUnknown_CDC     | P |
| PHVS_SerogroupMethod_RIBD | P |
| N/A                       | P |
| N/A                       | P |

|                                                                                                                                                                                 |   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| PHVS_YesNoUnknown_CDC                                                                                                                                                           | P |
| PHVS_YesNoUnknown_CDC                                                                                                                                                           | P |
| N/A                                                                                                                                                                             | P |
| N/A                                                                                                                                                                             | P |
| N/A                                                                                                                                                                             | P |
| N/A                                                                                                                                                                             | P |
| N/A                                                                                                                                                                             | P |
| PHVS_AgeUnit_UCUM                                                                                                                                                               | P |
| PHVS_InformationSource_RIBD                                                                                                                                                     | P |
| PHVS_YesNoUnknown_CDC                                                                                                                                                           | P |
| <a href="https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888">https://phinvads.cdc.gov/vads/ViewValueSet.action?oid=2.16.840.1.114222.4.11.888</a> |   |

CDC Priority (New)



| Label/Short Name                | Description                                                                                                        |
|---------------------------------|--------------------------------------------------------------------------------------------------------------------|
| COVID-19 ID                     | ID to link all case information on patient                                                                         |
| Interviewer Last Name           | Last name of interviewer                                                                                           |
| Interviewer First Name          | First name of interviewer                                                                                          |
| Interviewer Organization        | The affiliation or organization of the interviewer.                                                                |
| Interviewer Telephone           | Telephone number of interviewer                                                                                    |
| Interviewer Email               | Email of interviewer                                                                                               |
| Probable Classification Reason  | If probable case classification status, provide reason for classification.                                         |
| Process for Case Identification | Under what process was the case first identified?                                                                  |
| DGMQID                          | If EpiX notification of traveler, provide the DGMQID.                                                              |
| Positive Collection Date        | Date of first positive specimen collection.                                                                        |
| Hospital Translator             | If hospitalized, was a translator required?                                                                        |
| Translator Language             | If translator required in the hospital, specify which language?                                                    |
| Intensive Care Unit Admittance  | Was patient admitted to an intensive care unit (ICU)?                                                              |
| ICU Admission Date              | If patient was admitted to an ICU, provide the admission date.                                                     |
| ICU Discharge Date              | If patient was admitted to an ICU, provide the discharge date.                                                     |
| Housing Type                    | Select the best description of where the patient lived at the time of illness onset.                               |
| Health Care Worker              | Is the patient a health care worker in the U.S.?                                                                   |
| Health Care Worker Job Type     | If patient is a health care worker, select their occupation. If other, specify in text.                            |
| Health Care Worker Job Setting  | If patient is a health care worker, select their job setting. If other, specify in text.                           |
| Exposure of Interest            | In the 14 days prior to illness onset, did the patient have any of the following exposures? Select all that apply. |

|                                       |                                                                                                                                 |
|---------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| State of Travel Exposure              | If domestic travel outside of state of normal residence, specify the state.                                                     |
| Country of Travel Exposure            | If patient traveled internationally, specify country.                                                                           |
| Cruise Ship or Vessel                 | If exposed on a cruise ship or vessel, specify the name of the cruise ship.                                                     |
| Workplace Critical Infrastructure     | If the patient was exposed at their workplace, is the workplace critical infrastructure?                                        |
| Workplace Exposure                    | If workplace exposure, specify the workplace setting (e.g., long term healthcare setting, hospital, grocery store)              |
| Animal Case                           | If an animal with confirmed or suspected COVID-19, specify the animal.                                                          |
| Type of Contact with COVID-19 Case    | If the patient had contact with a known COVID-19 case, specify the type of contact.                                             |
| Contact with U.S. COVID-19 Case       | Was this person a U.S. case?                                                                                                    |
| COVID-19 Case Identifier              | If patient had contact with a known COVID-19 case, specify the COVID-19 ID(s).                                                  |
| Clinical History Collection Mechanism | Select which mechanisms were used for the collection of the clinical course, symptoms, past medical history and social history. |
| Symptomatic                           | Symptoms present during course of illness.                                                                                      |
| Symptoms Resolved                     | Did the patient's symptoms resolve?                                                                                             |
| Clinical Symptoms                     | Indicate the symptoms associated with this illness.                                                                             |
| Clinical Symptoms Indicator           | Indicator for each symptom.                                                                                                     |
| Diagnostic                            | Select the diagnostic tests that were performed.                                                                                |
| Diagnostic Result                     | Indicator for each diagnostic test result.                                                                                      |
| Treatment                             | Indicate the treatment received.                                                                                                |
| Treatment Indicator                   | Indicator for each treatment.                                                                                                   |
| Days of Mechanical Ventilation        | If patient received mechanical ventilation intubation, specify the total days of treatment.                                     |

|                                               |                                                                                                                                    |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|
| Underlying Risk Factors                       | Specify any of the underlying medical conditions and/or risk behaviors.                                                            |
| Underlying Risk Factors Indicator             | Indicator for each medical condition and risk behaviors.                                                                           |
| Chronic Disease                               | If other chronic diseases, please specify.                                                                                         |
| Underlying Condition                          | If other underlying condition, please specify.                                                                                     |
| Risk Behavior                                 | If other underlying risk behavior, please specify                                                                                  |
| Disability                                    | If disability (neurologic, neurodevelopmental, intellectual, physical, vision or hearing impairment, please specify.               |
| Psychological or Psychiatric Condition        | If psychological or psychiatric condition, please specify.                                                                         |
| Tribe Affiliation                             | Does this case have any tribal affiliation?                                                                                        |
| Tribe Name                                    | If case has tribal affiliation, provide tribe name.                                                                                |
| Tribe Enrolled Member                         | If case has tribal affiliation, indicate if case is an enrolled member.                                                            |
| Trimester at Onset of Illness                 | If the case-patient was pregnant at time of illness onset, indicate trimester of gestation at time of disease.                     |
| Number of Weeks Gestation at Onset of Illness | If the case-patient was pregnant at time of illness onset, specify the number of weeks gestation at onset of illness (1-45 weeks). |
| Exposure Indicator                            | Exposure indicator                                                                                                                 |
| Reason for Testing                            | Listing of the reason(s) the subject was tested for COVID-19                                                                       |
| Secondary Diagnosis                           | Did the patient have another diagnosis/etiology for their illness?                                                                 |
| Secondary Diagnosis Description               | If patient had another diagnosis/etiology for their illness, specify the diagnosis or etiology                                     |
| Clinical Finding                              | Clinical findings associated with the illness being reported                                                                       |
| Clinical Finding Indicator                    | Indicator for associated clinical findings                                                                                         |

|                                                             |                                                                                                                                                                                                                            |
|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Did the Subject Ever Receive a Vaccine Against This Disease | Did the subject ever receive a vaccine against this disease?                                                                                                                                                               |
| Vaccination Doses Prior to Onset                            | Number of vaccine doses against this disease prior to illness onset                                                                                                                                                        |
| Date of Last Dose Prior to Illness Onset                    | Date of last vaccine dose against this disease prior to illness onset                                                                                                                                                      |
| Vaccine History Comments                                    | Comments about the subject's vaccination history                                                                                                                                                                           |
| Date Left For Travel                                        | Date left for travel                                                                                                                                                                                                       |
| Date of Return from Travel                                  | Date of return from travel                                                                                                                                                                                                 |
| Primary Language                                            | What's case's primary language? Please indicate for both hospitalized and not hospitalized cases.                                                                                                                          |
| Information Source for Data                                 | Clinical information collected from which source(s)? Check all that apply                                                                                                                                                  |
| Did Underlying Condition(s) Exist                           | Did they have any underlying medical conditions and/or risk behaviors?                                                                                                                                                     |
| Previously Infected Individual                              | Did the subject meet the case definition for a previous case investigation of this disease or condition?                                                                                                                   |
| Previously Reported Jurisdiction Case Number                | If the subject previously met the case definition for the disease or illness, what was the previously submitted sending system-assigned local ID (case ID) of the case investigation with which the subject is associated? |
| WGS_ID                                                      | Genomic sequencing ID number.                                                                                                                                                                                              |
| Lineage                                                     | Lineage designation or sub-lineage, if available.                                                                                                                                                                          |

Value Set Code. Search in PHIN VADS using the following link (<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

CDC Priority (New)

|                       |  |   |
|-----------------------|--|---|
| N/A                   |  | 1 |
| N/A                   |  | 1 |
| N/A                   |  | 1 |
| N/A                   |  | 1 |
| N/A                   |  | 1 |
| N/A                   |  | 1 |
| N/A                   |  | 1 |
| TBD                   |  | 1 |
| TBD                   |  | 1 |
| N/A                   |  | 1 |
| N/A                   |  | 1 |
| PHVS_YesNoUnknown_CDC |  | 1 |
| TBD                   |  | 1 |
| PHVS_YesNoUnknown_CDC |  | 1 |
| N/A                   |  | 1 |
| N/A                   |  | 1 |
| TBD                   |  | 1 |
| PHVS_YesNoUnknown_CDC |  | 1 |
| TBD                   |  | 1 |
| TBD                   |  | 1 |
| TBD                   |  | 1 |

N/A

1

N/A

1

N/A

1

PHVS\_YesNoUnknown\_CDC

1

TBD

1

N/A

1

TBD

1

TBD

1

N/A

1

TBD

1

TBD

1

TBD

1

TBD

1

PHVS\_YesNoUnknown\_CDC

1

TBD

1

TBD

1

TBD

1

N/A

1

N/A

1

TBD

1

PHVS\_YesNoUnknown\_CDC

1

N/A

1

N/A

1

N/A

1

N/A

1

N/A

1

PHVS\_YesNoUnknown\_CDC

1

N/A

1

PHVS\_YesNoUnknown\_CDC

1

PHVS\_PregnancyTrimester\_CDC

2

N/A

2

PHVS\_YesNoUnknown\_CDC

1

TBD

3

PHVS\_YesNoUnknown\_CDC

3

N/A

3

PHVS\_ClinicalFinding\_COVID-19

1

PHVS\_YesNoUnknown\_CDC

1

PHVS\_YesNoUnknown\_CDC  
N/A

1

1

N/A

3

N/A

3

N/A

1

N/A

1

PHVS\_Language\_ISO\_639-2\_Alpha3

2

PHVS\_DataReportingSource\_COVID-19

3

PHVS\_YesNoUnknown\_CDC

1

[Yes No Unknown \(YNU\)](#)

1

N/A

1

N/A

2

N/A

2

Label/Short Name

Fever >38°C (100.4°F)

Feverish but temp not taken

Cough

Headache

Seizures

Sore throat

Conjunctivitis

Shortness of breath

Diarrhea

Other

Vaccinated

Vaccination date

Vaccine type

Antiviral medications

Date initiated oseltamivir

Date discontinued oseltamivir

Oseltamivir dosage

Zanamivir

Date initiated zanamivir

Date discontinued zanamivir

Rimantidine

Date initiated rimantidine

Date discontinued rimantidine

Amantidine

Date initiated amantidine

Date discontinued amantidine

Other antiviral (specify)

Date initiated other

Date discontinued other

Leukopenia

Lymphopenia

Thrombocytopenia

Underlying medical conditions

Compromised immune function

Compromised immune function  
specified

Mechanical ventilation

Chest x-ray/CAT

Pneumonia

ARDS

Death

Test 1 Specimen Type

Test 1 Date collected

Test 1 type

Test 2 Specimen Type  
Test 2 Date collected  
Test 2 type  
Specimens to CDC  
Epi Risk - Travel  
Country/Arrival/Departure  
Case close contact

Animal touch

Animal exposure

Environmental exposure

Raw/Undercooked animals

Animal contact  
Laboratory sample handling

HC setting  
Household illness contact

Household death contact

Porcine exposure

Porcine contact

Epidemiological link with lab-confirmed or probable case

## Description

Did/does the patient have a fever (specify max temp)?

Did/does the patient have a fever but temperature not taken?

Was cough a symptom?

Did/does the patient have a headache?

Did/does the patient have seizures?

Did/does the patient have a sore throat?

Did/does the patient have conjunctivitis?

Did/does the patient have shortness of breath?

Did/does the patient have shortness of breath?

Did/does the patient have any other symptoms (specify)?

Was the patient vaccinated against human influenza in the past year?

If yes, date of vaccination

If yes, type of vaccine received?

Did the patient receive antiviral medications?

What was the date that oseltamivir was initiated?

What was the date that oseltamivir was discontinued?

What was the dosage of oseltamivir?

What was the date that zanamivir was initiated?

What was the date that zanamivir was discontinued?

What was the dosage of zanamivir?

What was the date that rimantidine was initiated?

What was the date that rimantidine was discontinued?

What was the dosage of rimantidine?

What was the date that amantidine was initiated?

What was the date that amantidine was discontinued?

What was the dosage of amantidine?

What was the date that an other antiviral was initiated?

What was the date that an other antiviral was discontinued?

What was the dosage of an other antiviral?

Was leukopenia a lab finding?

Was lymphopenia a lab finding?

Was thrombocytopenia a lab finding?

Does the patient have any underlying medical conditions?

Does the patient have compromised immune function such as HIV infection, cancer, chronic corticosteroid therapy, diabetes, or organ transplant recipient?

If yes, specify function.

Did the patient require mechanical ventilation?

Did the patient have a chest x-ray or CAT scan performed?

If abnormal, was there evidence of pneumonia?

If abnormal, did the patient have acute respiratory distress syndrome??

Did the patient die as a result of this illness?

What was the specimen type for diagnostic test 1?

Date of collection of specimen for test 1?

What is the test type for diagnostic test 1?

What was the specimen type for diagnostic test 2?

Date of collection of specimen for test 2?

What is the test type for diagnostic test 2?

Indicate when and what type of specimens (including sera) were sent to CDC

In the 10 days prior to illness onset, did the patient travel?

If yes, fill in the arrival and departure dates for all countries visited.

Did the patient have close contact with a person who is a suspected, probable,, or confirmed novel human influenza A case?

Did the patient touch animals or their remains in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month?

Was the patient exposed to animal remains in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month?

Was the patient exposed to environments contaminated by animal feces in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month?

Did the patient consume raw or undercooked animals in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month?

Did the patient have any animal contact (specify)?

Did the patient handle samples suspected of containing influenza virus in a laboratory or other setting?

Does the patient work in a healthcare facility or setting?

Did the patient visit or stay in the same household with anyone with pneumonia or severe influenza-like illness?

Did the patient visit or stay in the same household with anyone who died following the visit?

Did the patient visit an agricultural event, farm, petting zoo, or place where pigs live or were exhibited in the last month?

Did the patient have direct contact with pigs at an agricultural event, farm, petting zoo, or place where pigs were exhibited in the last month?

If this patient has a diagnosis of novel influenza A virus infection that has not been serologically confirmed, is there an epidemiologic link between this patient and a lab-confirmed or probable novel influenza A case?

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

Label/Short Name

Autopsy

Cardiac/respiratory arrest

Location of death

Hospital Admission Date

Pathology specimens to CDC

Lab ID for pathology specimen

Isolates/original clinical material

Lab ID for isolates/clinical specimen

Staph aureus isolates

Lab ID for isolates

Commercial Rapid Diagnostic Test

Rapid test result

Rapid test specimen collection date

Viral Culture

Viral culture result

Viral culture specimen collection  
date

Fluorescent Antibody (IFA or DFA)

IFA/DFA result

IFA/DFA specimen collection date

Enzyme Immunoassay

EIA result

EIA collection date

RT-PCR test

RT-PCR result

RT-PCR specimen collection date

IHC test

IHC result

IHC specimen collection date

Bacterial Culture

Specimen Type

Collection Date

Bacterial Culture Results

Bacterial culture species isolated

Other Respiratory Specimen/ Non-  
sterile site

Other respiratory specimen site

Other respiratory specimen site

Other respiratory specimen  
collection date

Other respiratory specimen result

Bacterial species cultured  
Autopsy Specimen

Autopsy Specimen Results

Mechanical Ventilation  
Complications  
Type complications

Existing Medical Conditions

Medical conditions before acute  
illness

Medications and/or Therapies  
Medications received before illness

Medications received after illness

Influenza Vaccine

Vaccine before illness

1 Dose <14 days

1 Dose >14 days

2 Dose <14 days

2 Dose >14 days

Previous Seasonal Vaccine

1 Dose Seasonal

2 Dose Seasonal

1 Dose AT Least

## Description

Was an autopsy performed on the patient?

Did the patient experience cardiac/respiratory arrest outside the hospital?

What was the location of the patient's death?

If patient's death occurred in a hospital, what was the date of admission?

Were pathology specimens sent to CDC's Infectious Diseases Pathology Branch?

Provide the lab ID number(if known) for pathology specimen(s) sent to CDC.

Were influenza isolates or original clinical material sent to CDC Influenza Division?

Provide the lab ID number(if known) for isolates/clinical specimen(s) sent to CDC.

Were staph aureus isolates sent to CDC's Healthcare Quality Promotion?

Provide the lab ID number(if known) for isolate(s) sent to CDC.

Indicate if commercial rapid test used.

What is the result of the rapid test?

What is the specimen collection date for the rapid test?

Indicate if viral culture used.

What is the result of the viral culture?

What is the specimen collection date for the viral culture?

Indicate if fluorescent antibody test used.

What is the result of the IFA/DFA?

What is the specimen collection date for the IFA/DFA?

Indicate if enzyme immunoassay used.

What is the result of the EIA?

What is the specimen collection date for the EIA?

Indicate if an RT-PCR test was used.

What is the result of the RT-PCR?

What is the specimen collection date for the RT-PCR?

Indicate if an immunohistochemistry test was used.

What is the result of the IHC?

What is the specimen collection date for the IHC?

Was a specimen collected for bacterial culture from a normally sterile site?

What was the specimen type obtained for the bacterial culture? This is a multi-select field.

What was the collection date for the bacterial culture?

What was the result of the bacterial culture?

If bacterial culture positive, check the organism cultured. This is a multi-select field.

Were other respiratory specimens from non-sterile site(s) collected for bacterial culture (e.g., sputum, ET tube aspirate)?

If yes, indicate the site from which the specimen was obtained. This is a multi-select field.

If yes, indicate the date collected of the specimen.

If yes, indicate the date collected of the specimen.

If yes, indicate the result for the specimen culture.

If positive, what was the organism cultured?

Was a specimen (e.g., fixed lung tissue) collected from an autopsy for bacterial pathogen testing?

If autopsy specimen was taken, what were the results (indicate in the comments section)?

Was the patient placed on mechanical ventilation?

Did complications occur during the acute illness?

If yes, check all complications that occurred during the acute illness. This is a multi-select field.

Did the child have any medical conditions that existed before the start of the acute illness?

If yes, check all medical conditions that existed before the start of the acute illness. This is a multi-select field

Was the patient receiving any of the listed therapies prior to illness onset?

Check all medications/therapies patient was receiving before the acute illness. This is a multi-select field.

Did the patient receive any of the following after illness onset? This is a multi-select field.

Did the patient receive any seasonal influenza vaccine during the current season (before illness)?

If yes, specify the seasonal vaccine received before illness onset.

If yes, did patient receive 1 dose of vaccine <14 days prior to illness onset (date given)?

If yes, did patient receive 1 dose of vaccine  $\geq 14$  days prior to illness onset (date given)?

If yes, did patient receive vaccines <14 days prior to illness onset (dates given)?

If yes, did patient receive 2 doses of vaccines  $\geq 14$  days prior to illness onset (dates given)?

Did the patient receive any seasonal influenza vaccine in previous seasons?

If yes, and patient was between 6 months and  $\leq 8$  years of age at the time of death, was the 2009-2010 influenza season the first time the patient received seasonal influenza vaccine?

If yes, did patient receive 2 doses of seasonal influenza vaccine during the 2009-2010 influenza season?

If the patient was between 6 months and  $\leq 8$  years of age at the time of death, did they receive at least 1 dose of 2009 influenza A (H1N1) vaccine during the previous season?

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

Label/Short Name

Did the patient have a cough?

Cough Onset Date

Paroxysmal Cough

Whoop

Post-tussive Vomiting

Apnea

Date of Final Interview

Did the patient have a cough at final interview?

Total Cough Duration

Result of chest X-ray for pneumonia

Did the patient have generalized or focal seizures due to pertussis?

Did the patient have acute encephalopathy due to pertussis?

Were antibiotics given?

Antibiotic Name

Antibiotic Start Date

Number of days antibiotic actually taken.

Second antibiotic patient received?

Date second antibiotic started

Number of days second antibiotic actually taken

Was laboratory testing done for pertussis?

Test Type

Test Result

Date Collected

Did the subject ever receive a disease-containing vaccine?

Vaccine Administered

Vaccine Manufacturer

Vaccine Lot Number

Vaccine Administered Date

Is this case epi-linked to a laboratory-confirmed case?

Is this case part of a cluster or outbreak (e.g. total is 2 or more cases)?

Transmission Setting

Was there documented transmission from this case of pertussis to a new setting? (not in household)

Number of contacts of this case recommended to receive antibiotic prophylaxis

Age of person contracted patient contracted pertussis from

Age Type

Setting where patient contracted pertussis

Specify In which setting was pertussis acquired.

Specify In which setting was there secondary spread

Name Of Contacts

Birth Date of contacts

Contact Relationship to Subject

Case?

Contact Case ID

Cough Onset Date(If Present

Number of PCVs\*

Date of Last PCV

Parent's Name (If Applicable)

Parent's Phone # (If Applicable)

Cyanosis

Treatment Drug, Other

Case patient a healthcare worker

Mother's age at infant's birth

Gestational age in weeks

Birth Weight

Birth Weight Units

Did mother receive Tdap?

Timing of mother's Tdap administration

Date of mother's Tdap administration

One or more suspected sources?

Number of suspected sources?

Suspected source sex

Suspected source relationship to case (other)

Patient Address City

Case Investigation Status Code

Detection Method  
Age at cough onset  
Age type at cough onset  
Laboratory Confirmed  
Specimen sent to CDC  
Type of testing at CDC  
Type of testing at CDC, Other  
Date specimen sent to CDC  
VPD Lab Message Patient Identifier  
VPD Lab Message Observation Identifier  
VPD Lab Message Observation Value

Test Type, Other  
Specimen ID Placer Assigned Identifier  
Specimen ID Filler Assigned Identifier

Performing Laboratory Type  
Performing Laboratory Type, Other  
Numeric Test Result  
Numeric Test Result Units  
Vaccinated per ACIP recommendations  
Reason not vaccinated per ACIP recommendations  
Reason not vaccinated per ACIP, Other  
Vaccine Administered Product Type, Other  
NDC Brand Name/Bar Code information  
Vaccine Product Manufacturer, Other  
Vaccine Lot Expiration Date  
Vaccination Record ID  
Reason immunization not given, regardless of the schedule used  
Other transmission setting  
Setting of further spread  
Suspected source relation to case  
Estimated cough onset date of suspected source

## Description

Did the patient's illness include the symptom of cough?

Cough onset date

Did the patient's illness include the symptom of paroxysmal cough?

Did the patient's illness include the symptom of whoop?

Did the patient's illness include the symptom of post-tussive vomiting?

Did the patient's illness include the symptom of apnea?

Date of the patient's final interview

Was there a cough at the patient's final interview?

What was the duration (in days) of the patient's cough?

Result of chest x-ray for pneumonia

Did the patient have generalized or focal seizures due to pertussis?

Did the patient have acute encephalopathy due to pertussis?

Were antibiotics given to the patient?

What antibiotic did the patient receive?

Date the patient first started taking the antibiotic

Number of days the patient actually took the antibiotic referenced

If Other, please specify antibiotic

Date second antibiotic started

Number of days second antibiotic actually taken

Was laboratory testing done for pertussis?

Epidemiologic interpretation of the type of test(s) performed for this case

Epidemiologic interpretation of the results of the tests performed for this case.

Date of specimen collection

Did the patient ever receive a pertussis-containing vaccine?

The type of vaccine administered.

Manufacturer of the vaccine.

The vaccine lot number of the vaccine administered.

The date that the vaccine was administered.

Is this case epi-linked to a laboratory-confirmed case?

Is this case part of a cluster or outbreak (e.g. total is 2 or more cases)?

Transmission setting (Where did this case acquire pertussis?)

Was there documented transmission (outside of the household) for transmission from this case?

Number of contacts of this case recommended to receive antibiotic prophylaxis

Age of the person from whom this patient contracted pertussis

Age Type

Transmission setting (Where did this patient acquire pertussis?)

setting in which pertussis was acquired

In which setting was there secondary spread

Name Of Contacts

Birth Date of contacts

Relationship of contact

Case

Unique case identifier of the contact. This would be the same as INV168 (Case Local ID)

Cough Onset Date(If Present

Number of PCVs\*

Date of Last PCV

Parent's Name (If Applicable)

Parent's Phone # (If Applicable)

Did patient have cyanosis during his/her illness?

If other, specify antibiotic used

Was case patient healthcare personnel (HCP) (at illness onset)?

Mother's age at infant's birth (used only if patient under 12 months old)

Gestational age (if case-patient < 1 year of age at illness onset)

Infant's birth weight (used only if patient under 12 months old)

Infant's birth weight units

Did mother receive Tdap (if case-patient < 1 year of age at illness onset)?

If mother received Tdap, when was it administered?

If mother received Tdap, what date was it administered? \*(if available)

Was there one or more suspected sources of infection? (from NBS MM)

Number of suspected sources? (from NBS MM)

Suspected source sex (from NBS MM)

Suspected source relationship to case (other)

Patient Address City, from NBS MM

Case Investigation Status Code, from NBS MM

Detection Method, from NBS MM

Age of patient at cough onset

Age units at cough onset

Was the case laboratory confirmed?

Was a specimen sent to CDC for testing?

What type of testing was done at CDC for this subject?

If other, specify testing done at CDC

Date specimen sent to CDC

VPD Lab Message Patient Identifier

VPD Lab Message Observation Identifier

VPD Lab Message Observation Value

If other, specify lab test

Specimen ID Placer Assigned Identifier

Specimen ID Filler Assigned Identifier

Performing Laboratory Type

If other, specify performing laboratory type

Numeric Result Value

The unit of measure for numeric result value.

Was subject vaccinated as recommended by ACIP?

Reason subject not vaccinated as recommended by ACIP

If other, specify reason not vaccinated per ACIP

If other, specify type of vaccine administered

NDC from the vaccine's bar code. With the NDC code, vaccine brand name and manufacturer can be obtained.

If other, specify vaccine manufacturer

Vaccine expiration date

Vaccination Record ID, from NBS MM

Reason subject was not vaccinated, regardless of the immunization schedule used

If other, specify the other transmission setting

If other, specify transmission setting of further spread

Suspected source of infection relationship to case

Estimated cough onset date of suspected source of infection

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_ChestXrayResult\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_AntibioticReceived\_Pertussis

PHVS\_AntibioticReceived\_Pertussis

PHVS\_YesNoUnknown\_CDC

PHVS\_LabTestProcedure\_Pertussis

PHVS\_LabTestInterpretation\_Pertussis

PHVS\_YesNoUnknown\_CDC

PHVS\_VaccinesAdministeredCVX\_CDC\_NIP

PHVS\_ManufacturersOfVaccinesMVX\_CDC\_NIP

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_TransmissionSetting\_NND

PHVS\_YesNoUnknown\_CDC

Age\_Type  
PHVS\_TransmissionSetting\_NND

PHVS\_Relationship\_Flu

| Label/Short Name                             | Description                                                                        |
|----------------------------------------------|------------------------------------------------------------------------------------|
| Primary plague type                          | Classification of primary clinical manifestation of infection                      |
| Animal Contact                               | Contact with sick or dead animals                                                  |
| Flea bite                                    | Flea bite                                                                          |
| Immunocompromised                            | If patient has any immunocompromising conditions, specify                          |
| Date first medical                           | Date that the patient was first seen by medical person.                            |
| Fever/sweats/chills                          | Did the patient's illness include the symptom of fever/sweats/chills?              |
| Confusion/delirium                           | Did the patient's illness include the symptom of confusion/delirium?               |
| Vomiting/diarrhea/abdominal pain             | Did the patient's illness include the symptom of vomiting/diarrhea/abdominal pain? |
| Sore throat                                  | Did the patient's illness include the symptom of sore throat?                      |
| Cough                                        | Did the patient's illness include the symptom of cough?                            |
| Chest Pain                                   | Did the patient's illness include the symptom of chest pain?                       |
| Shortness of breath                          | Did the patient's illness include the symptom of shortness of breath?              |
| Other_symptoms                               | Did the patient's illness include other symptoms of not listed?                    |
| Other_symptoms_specify                       | Which other symptoms did the patient's illness include?                            |
| Bubo                                         | Did patient have bubo?                                                             |
| Type of Bubo                                 | Specify type of bubo                                                               |
| Location/description Bubo                    | Describe location and appearance of bubo                                           |
| Insect bites/skin ulcer                      | Did patient have any insect bites/skin ulcer                                       |
| Location/description insect bites/skin ulcer | Describe location and appearance of insect bites/skin ulcer                        |
| Chest X-ray                                  | Results of chest x-ray                                                             |
| Antibiotic                                   | Did patient receive an effective antibiotic for illness?                           |
| Antibiotic start date                        | Date each antibiotic started                                                       |
| Illness outcome                              | Outcome of illness                                                                 |
| Primary plague type                          | Classification of primary clinical manifestation of infection                      |
| Secondary pneumonic plague                   | Did patient have secondary pneumonic plague?                                       |
| <i>Y. pestis</i> cultured                    | Was <i>Y. pestis</i> cultured?                                                     |
| Specimen source                              | Source of culture                                                                  |
| Date specimen collected                      | Date specimen was collected                                                        |
| <i>Y. pestis</i> detected                    | Was <i>Y. pestis</i> detected by other tests?                                      |
| Test performed                               | Test used to detect <i>Y. pestis</i>                                               |
| Specimen source                              | Specimen source in which <i>Y. pestis</i> was detected                             |
| Date specimen collected                      | Date of specimen collection                                                        |
| Serology                                     | Serology results                                                                   |
| First Serum titer                            | Titer of first serum specimen                                                      |
| Second Serum titer                           | Titer of second serum specimen                                                     |
| Date first serum drawn                       | Date first serum drawn                                                             |
| Date second serum drawn                      | Date second serum drawn                                                            |

|                                       |                                                                                             |
|---------------------------------------|---------------------------------------------------------------------------------------------|
| Epi-linked to any other plague cases  | Was this illness epi-linked to any other plague cases?                                      |
| Likely location of exposure           | Most likely location of exposure                                                            |
| Animal contact                        | Did patient have any animal contact in the 2 weeks preceding illness?                       |
| Nature of contact                     | Nature of animal contact in the 2 weeks preceding illness                                   |
| Type of animal contact                | Was animal domestic or wild                                                                 |
| Flea bite or insect bites             | Did patient have flea or insect bites in the 2 weeks preceding illness?                     |
| Wild animal                           | Specify wild animal that patient had contact with in the 2 weeks preceding illness          |
| Domestic animal                       | Specify domestic animal that patient had contact with in the 2 weeks preceding illness      |
| Evidence of infected animals or fleas | Evidence of infected animals or fleas in the likely exposure location                       |
| Specify infected animals or fleas     | Describe evidence of <i>Y. pestis</i> infected animals or fleas in likely exposure location |
| Other exposure                        | Specify any other exposures in the two weeks preceding illness                              |
| Comments                              | Additional comments                                                                         |
| Person to person transmission         | Evidence of person to person transmission from a known plague patient                       |

Value Set Code. Search in PHIN  
VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

|                       |   |
|-----------------------|---|
| TBD                   | P |
| TBD                   | P |
| TBD                   | P |
| N/A                   | P |
| N/A                   | P |
| PHVS_YesNoUnknown_CDC | P |
| PHVS_YesNoUnknown_CDC | P |
| PHVS_YesNoUnknown_CDC | P |
| PHVS_YesNoUnknown_CDC | P |
| PHVS_YesNoUnknown_CDC | P |
| PHVS_YesNoUnknown_CDC | P |
| PHVS_YesNoUnknown_CDC | P |
| PHVS_YesNoUnknown_CDC | P |
| PHVS_YesNoUnknown_CDC | P |
| N/A                   | P |
| PHVS_YesNoUnknown_CDC | P |
| TBD                   | P |
| N/A                   | P |
| PHVS_YesNoUnknown_CDC | P |
| N/A                   | P |
| TBD                   | P |
| TBD                   | P |
| TBD                   | P |
| TBD                   | P |
| PHVS_YesNoUnknown_CDC | P |
| PHVS_YesNoUnknown_CDC | P |
| N/A                   | P |
| N/A                   | P |
| PHVS_YesNoUnknown_CDC | P |
| N/A                   | P |
| N/A                   | P |
| N/A                   | P |
| TBD                   | P |
| N/A                   | P |
| N/A                   | P |
| N/A                   | P |
| N/A                   | P |

|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | P |
| TBD                   | P |
| PHVS_YesNoUnknown_CDC | P |
| TBD                   | P |
| TBD                   | P |
| PHVS_YesNoUnknown_CDC | P |
| N/A                   | P |
| N/A                   | P |
| PHVS_YesNoUnknown_CDC | P |
| N/A                   | P |
| N/A                   | P |
| N/A                   | P |
| PHVS_YesNoUnknown_CDC | P |

Label/Short Name

Paralysis onset date

Clinical course

CSF date

WBCs

RBCs

%Lymph

%polys

Protein

Glucose

60-day follow up date

Paralysis site

Specific sites

60-day residual

TOPV immunization history

Date of TOPV

Lot number

IPV-containing vaccine

Date 1 IPV

Date 2 IPV

Date 3 IPV

TOPV vaccine

Date 1 TOPV

Date 2 TOPV

Date 3 TOPV

BOPV vaccine

Date 1 BOPV

Date 2 BOPV

Date 3 BOPV

MOPV vaccine

Date 1 MOPV

Date 2 MOPV

Date 3 MOPV

First injection date

Substance

Describe

First injection site

Second injection date

Substance

Describe

Second injection site

Third injection date

Substance

Describe

Third injection site

Fourth injection date

Substance  
Describe  
Fourth injection site  
Travel to endemic/epidemic area(s)

Exposure location(s) 1  
Departure date 1  
Return date 1  
Exposure to person(s) from or  
returning to endemic areas  
Exposure location(s) 2

Departure date 2  
Return date 2  
Contact with known case  
Contact name  
Exposure to case location  
Contact date  
OVP recipient contact  
OVP recipient contact  
OVP recipient relation  
OVP recipient age  
OPV recipient agetype  
Date received OVP  
OVP dose number  
OVP lot number  
State or local laboratory name  
Serum 1  
Serum 1 test type  
Serum 1 result  
Serum 1 date  
Serum 2  
Serum 2 test type  
Serum 2 result  
Serum 2 date  
Specimen 1 results  
Specimen 1 laboratory  
Specimen 1 type  
Specimen 1 date  
Specimen 2 results  
Specimen 2 laboratory  
Specimen 2 type  
Specimen 2 date  
CDC serum 1  
CDC serum 1 test type  
CDC serum 1 result  
CDC serum 1 date

CDC serum 2  
CDC serum 2 test type  
CDC serum 2 result  
CDC serum 2 date  
CDC specimen 1 type  
CDC specimen 1 results  
CDC specimen 1 strain results  
CDC specimen 1 date received  
CDC specimen 1 obtained  
CDC specimen 2 type  
CDC specimen 2 results  
CDC specimen 2 strain results  
CDC specimen 2 date received  
CDC specimen 2 obtained  
EMG  
EMG results  
EMG date  
Nerve conduction  
Nerve results  
Nerve conduction date  
Immune deficiency  
Immune deficiency diagnosis  
Immune studies  
HIV status

## Description

Date of onset of paralysis

Clinical course

Date of CSF results

White blood cell test results for cerebral spinal fluid

Red blood cell test results for cerebral spinal fluid

%lymphs test results for CSF

%polys test results for CSF

Protein test results for CSF

Glucose test results for CSF

Date of 60-day follow up

Sites of paralysis

Specific sites of paralysis

60-day paralysis residual

TOPV within 30 days prior to onset of symptoms?

TOPV immunization date

TOPV vaccine lot number

Total doses ever received of IPV-containing vaccine

First IPV vaccine date

Second IPV vaccine date

Third IPV vaccine date

Total doses ever received of TOPV vaccine

First TOPV vaccine date

Second TOPV vaccine date

Third TOPV vaccine date

Total doses ever received of BOPV vaccine

First BOPV vaccine date

Second BOPV vaccine date

Third BOPV vaccine date

Total doses ever received of MOPV vaccine

First MOPV vaccine date

Second MOPV vaccine date

Third MOPV vaccine date

Date of first injection received within 30 days prior to onset of illness

Substance (vaccine, antibiotic, other) of first injection

Description of first injection substance

Site of first injection

Date of second injection received within 30 days prior to onset of illness

Substance (vaccine, antibiotic, other) of second injection

Description of second injection substance

Site of second injection

Date of third injection received within 30 days prior to onset of illness

Substance (vaccine, antibiotic, other) of third injection

Description of third injection substance

Site of third injection

Date of fourth injection received within 30 days prior to onset of illness

Substance (vaccine, antibiotic, other) of fourth injection  
Description of fourth injection substance  
Site of fourth injection  
Did case/household member travel to endemic/epidemic area(s)?

Locations of exposure of case/household member  
Date of travel departure  
Date of travel return  
Was case/household members exposed to persons from or returning to endemic areas?  
Locations of exposure to case/household member who traveled/is from endemic area

Date of travel departure of person to whom exposed  
Date of travel return of person to whom exposed  
Did case/household member have contact with known case?  
Name of case contact (last, first)  
Location of exposure to case?  
Date of contact with known case  
Did case have contact with OPV vaccine recipient  
If yes, date of contact with household OVP vaccine  
Relationship of household OVP vaccine recipient to case  
Age of the OVP vaccine recipient  
Agetype of the OVP vaccine recipient  
Date contact received OVP vaccine  
Number of doses of OVP vaccine received by contact  
Lot number of OVP vaccine received by contact  
Name of state or local laboratory which received serum specimens  
Indicate whether P1, P2, or P3  
Test type (neut/CSF)  
Test result for serum 1  
Date drawn/obtained for serum1  
Indicate whether P1, P2, or P3  
Test type (neut/CSF)  
Test result for serum 2  
Date drawn/obtained for serum 2  
Results of specimen 1 sent for viral isolation  
Name of laboratory which received specimens for viral isolation  
Type specimen 1 submitted for viral isolation  
Date drawn/obtained for specimen 1  
Results of specimen 2 sent for viral isolation  
Name of laboratory which received specimens for viral isolation  
Type specimen 2 submitted for viral isolation  
Date drawn/obtained for specimen 2  
Indicate whether P1, P2, or P3 (serum sent to CDC lab)  
Test type (neut/CSF for serum sent to CDC lab)  
Test result for serum 1 (sent to CDC lab)  
Date drawn/obtained for serum 1 (sent to CDC)

Indicate whether P1, P2, or P3  
Test type (neut/CSF for serum sent to CDC lab))  
Test result for serum 2 (sent to CDC lab)  
Date drawn/obtained for serum 2 (sent to CDC lab)  
Type specimen 1 submitted for viral isolation (to CDC lab)  
Results of specimen 1 sent for viral isolation (to CDC lab)  
Strain characterization results for specimen 1  
Date specimen 1 received by CDC lab  
Date specimen 1 obtained for CDC testing  
Type specimen 2 submitted for viral isolation (to CDC lab)  
Results of specimen 2 sent for viral isolation (to CDC lab)  
Strain characterization results for specimen 2  
Date specimen 2 received by CDC lab  
Date specimen 2 obtained for CDC testing  
Was an EMG performed?  
What were the results of the EMG?  
Indicate date of EMG.  
Was a nerve conduction performed?  
What were the results of the nerve conduction?  
Indicate date of the nerve conduction.  
Was an immune deficiency diagnosed prior to OPV exposure?  
What was the specific diagnosis?  
Indicate any immune studies performed  
What is the HIV status of the patient?

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

Label/Short Name

Clinical course

CSF date

WBCs

RBCs

%Lymph

%polys

Protein

Glucose

60-day follow up date

TOPV immunization history

Date of TOPV

Lot number

IPV-containing vaccine

Date 1 IPV

Date 2 IPV

Date 3 IPV

TOPV vaccine

Date 1 TOPV

Date 2 TOPV

Date 3 TOPV

BOPV vaccine

Date 1 BOPV

Date 2 BOPV

Date 3 BOPV

MOPV vaccine

Date 1 MOPV

Date 2 MOPV

Date 3 MOPV

First injection date

Substance

Describe

First injection site

Second injection date

Substance

Describe

Second injection site

Third injection date

Substance

Describe

Third injection site

Fourth injection date

Substance

Describe

Fourth injection site

Travel to endemic/epidemic area(s)

Exposure location(s) 1

Departure date 1

Return date 1

Exposure to person(s) from or  
returning to endemic areas

Exposure location(s) 2

Departure date 2

Return date 2

Contact with known case

Contact name

Exposure to case location

Contact date

OVP recipient contact

OVP recipient contact

OVP recipient relation

OVP recipient age

OPV recipient agetype

Date received OVP

OVP dose number

OVP lot number

State or local laboratory name

Serum 1

Serum 1 test type

Serum 1 result

Serum 1 date

Serum 2

Serum 2 test type

Serum 2 result

Serum 2 date

Viral Isolation Specimen 1 results

Specimen 1 laboratory

Specimen 1 type

Specimen 1 date

Specimen 2 results

Specimen 2 laboratory

Specimen 2 type

Specimen 2 date

CDC serum 1

CDC serum 1 test type

CDC serum 1 result

CDC serum 1 date

CDC serum 2

CDC serum 2 test type

CDC serum 2 result

CDC serum 2 date  
CDC specimen 1 type  
CDC specimen 1 results  
CDC specimen 1 strain results  
CDC specimen 1 date received  
CDC specimen 1 obtained  
CDC specimen 2 type  
CDC specimen 2 results  
CDC specimen 2 strain results  
CDC specimen 2 date received  
CDC specimen 2 obtained  
EMG  
EMG results  
EMG date  
Nerve conduction  
Nerve results  
Nerve conduction date  
Immune deficiency  
Immune deficiency diagnosis  
Immune studies  
HIV status

## Description

Clinical course

Date of CSF results

White blood cell test results for cerebral spinal fluid

Red blood cell test results for cerebral spinal fluid

%lymphs test results for CSF

%polys test results for CSF

Protein test results for CSF

Glucose test results for CSF

Date of 60-day follow up

TOPV within 30 days prior to onset of symptoms?

TOPV immunization date

TOPV vaccine lot number

Total doses ever received of IPV-containing vaccine

First IPV vaccine date

Second IPV vaccine date

Third IPV vaccine date

Total doses ever received of TOPV vaccine

First TOPV vaccine date

Second TOPV vaccine date

Third TOPV vaccine date

Total doses ever received of BOPV vaccine

First BOPV vaccine date

Second BOPV vaccine date

Third BOPV vaccine date

Total doses ever received of MOPV vaccine

First MOPV vaccine date

Second MOPV vaccine date

Third MOPV vaccine date

Date of first injection received within 30 days prior to onset of illness

Substance (vaccine, antibiotic, other) of first injection

Description of first injection substance

Site of first injection

Date of second injection received within 30 days prior to onset of illness

Substance (vaccine, antibiotic, other) of second injection

Description of second injection substance

Site of second injection

Date of third injection received within 30 days prior to onset of illness

Substance (vaccine, antibiotic, other) of third injection

Description of third injection substance

Site of third injection

Date of fourth injection received within 30 days prior to onset of illness

Substance (vaccine, antibiotic, other) of fourth injection

Description of fourth injection substance

Site of fourth injection

Did case/household member travel to endemic/epidemic area(s)?

Locations of exposure of case/household member

Date of travel departure

Date of travel return

Was case/household members exposed to persons from or returning to endemic areas?

Locations of exposure to case/household member who traveled/is from endemic area

Date of travel departure of person to whom exposed

Date of travel return of person to whom exposed

Did case/household member have contact with known case?

Name of case contact (last, first)

Location of exposure to case?

Date of contact with known case

Did case have contact with OPV vaccine recipient

If yes, date of contact with household OVP vaccine

Relationship of household OVP vaccine recipient to case

Age of the OVP vaccine recipient

Agetype of the OVP vaccine recipient

Date contact received OVP vaccine

Number of doses of OVP vaccine received by contact

Lot number of OVP vaccine received by contact

Name of state or local laboratory which received serum specimens

Indicate whether P1, P2, or P3

Test type (neut/CSF)

Test result for serum 1

Date drawn/obtained for serum1

Indicate whether P1, P2, or P3

Test type (neut/CSF)

Test result for serum 2

Date drawn/obtained for serum 2

Results of specimen 1 sent for viral isolation

Name of laboratory which received specimens for viral isolation

Type specimen 1 submitted for viral isolation

Date drawn/obtained for specimen 1

Results of specimen 2 sent for viral isolation

Name of laboratory which received specimens for viral isolation

Type specimen 2 submitted for viral isolation

Date drawn/obtained for specimen 2

Indicate whether P1, P2, or P3 (serum sent to CDC lab)

Test type (neut/CSF for serum sent to CDC lab)

Test result for serum 1 (sent to CDC lab)

Date drawn/obtained for serum 1 (sent to CDC)

Indicate whether P1, P2, or P3

Test type (neut/CSF for serum sent to CDC lab))

Test result for serum 2 (sent to CDC lab)

Date drawn/obtained for serum 2 (sent to CDC lab)  
Type specimen 1 submitted for viral isolation (to CDC lab)  
Results of specimen 1 sent for viral isolation (to CDC lab)  
Strain characterization results for specimen 1  
Date specimen 1 received by CDC lab  
Date specimen 1 obtained for CDC testing  
Type specimen 2 submitted for viral isolation (to CDC lab)  
Results of specimen 2 sent for viral isolation (to CDC lab)  
Strain characterization results for specimen 2  
Date specimen 2 received by CDC lab  
Date specimen 2 obtained for CDC testing  
Was an EMG performed?  
What were the results of the EMG?  
Indicate date of EMG.  
Was a nerve conduction performed?  
What were the results of the nerve conduction?  
Indicate date of the nerve conduction.  
Was an immune deficiency diagnosed prior to OPV exposure?  
What was the specific diagnosis?  
Indicate any immune studies performed  
What is the HIV status of the patient?

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

Label/Short Name

Clinical description

Specific therapy

Outcome

Death date

Acute-phase serum

Acute-phase serum collected

Acute-phase serum IgM test result

Acute-phase serum IgG test result

Acute-phase serum lab

Convalescent-phase serum

Convalescent-phase serum collected

Convalescent-phase serum IgM test  
result

Convalescent-phase serum IgG test  
result

Convalescent-phase serum lab

PCR

PCR collected

PCR test result

PCR specimen lab

Sputum culture collected

Sputum culture test result

Sputum culture lab

Chest x-ray

Chest x-ray date

Chest x-ray results

Onset Date Occupation

Specific duties

Contact types prior to onset

Psittacine contact

Pigeons

Domestic fowl

Other birds

Healthy birds

Private home - owner

Private home - address

Private home - species

Private home - setting

Private home - date  
Private aviary - owner  
Private aviary - adress  
Private aviary - species  
Private aviary -setting  
Private aviary - date  
Coomercial aviary - owner  
Coomercial aviary - address  
Coomercial aviary - species  
Coomercial aviary - setting  
Coomercial aviary - date  
Pet shop - owner  
Pet shop - address  
Pet shop - species  
Pet shop - setting  
Pet shop - date  
Bird loft - owner  
Bird loft - address  
Bird loft - species  
Bird loft - setting  
Bird loft - date  
Poultry establishment - owner  
Poultry establishment - address  
Poultry establishment - species  
Poultry establishment - setting  
Poultry establishment - date  
Other - owner  
Other - address  
Other - species  
Other - setting  
Other - date  
Unknown - owner  
Unknown - address  
Unknown - species  
Unknown - setting  
Unknown - date  
Other epi link  
Implicated birds

Additional revelant information  
Signs and Symptoms

Signs and Symptoms Indicator  
Highest Measured Temperature  
Temperature Units  
Antibiotics given

Treatment Start Date  
Treatment End Date  
Treatment Duration  
Hospital ICU

Laboratory Testing Performed  
Laboratory Confirmed  
Test Manufacturer  
Autopsy Specimen Type  
Autopsy Result  
Date of Autopsy  
Autopsy Laboratory Name  
Industry at Date of Onset  
Personal Protective Equipment

Respiratory Protective Equipment

Annual Respirator Fit Testing and  
Training

Glove Material  
Contact Type  
Bird Type

Bird Species  
Number of Birds  
Illness Onset Age  
Illness Onset Age Units

## Description

Check all signs and symptoms listed below (note maximum temperature). This is a multi-select field.

Specify products, dosage, and duration.

What was the outcome of this illness?

If patient died, date of death.

What was the acute-phase serum test method?

What was the acute-phase serum collection date?

What was the acute-phase serum IgM result?

What was the acute-phase serum IgG result?

What was the laboratory name?

What was the convalescent-phase serum test method?

What was the convalescent-phase serum collection date?

What was the convalescent-phase serum IgM result?

What was the convalescent-phase serum IgG result?

What was the laboratory name?

What was the PCR test specimen type?

What was the PCR specimen collection date?

What was the PCR test result?

What was the laboratory name?

What was the sputum specimen collection date?

What was the sputum specimen test result?

What was the laboratory name?

Was a chest x-ray done?

When was the chest x-ray done?

What was the chest x-ray result?

What was the patient's occupation at date of onset?

What are/were the patient's specific duties?

Indicate which of the following contacts the patient had during the 5 weeks prior to onset.

If exposure to birds, did the patient have contact with psittacines (species, approximate number and were birds healthy)?

If exposure to birds, did the patient have contact with pigeons (species, approximate number and were birds healthy)?

If exposure to birds, did the patient have contact with domestic fowl (species, approximate number and were birds healthy)?

If exposure to birds, did the patient have contact with any other birds (species, approximate number and were birds healthy)?

If birds were not healthy, please elaborate.

Indicate the owner of the private home

Indicate the address of the private home

Indicate the species to which exposed

Indicate the exposure setting (indoor, outdoor)

Indicate the date of exposure  
 Indicate the owner of the aviary  
 Indicate the address of the aviary  
 Indicate the species to which exposed  
 Indicate the exposure setting (indoor, outdoor)  
 Indicate the date of exposure  
 Indicate the owner of the aviary  
 Indicate the address of the aviary  
 Indicate the species to which exposed  
 Indicate the exposure setting (indoor, outdoor)  
 Indicate the date of exposure  
 Indicate the owner of the pet shop  
 Indicate the address of the pet shop  
 Indicate the species to which exposed  
 Indicate the exposure setting (indoor, outdoor)  
 Indicate the date of exposure  
 Indicate the owner of the bird loft  
 Indicate the address of the bird loft  
 Indicate the species to which exposed  
 Indicate the exposure setting (indoor, outdoor)  
 Indicate the date of exposure  
 Indicate the owner of the establishment  
 Indicate the address of the establishment  
 Indicate the species to which exposed  
 Indicate the exposure setting (indoor, outdoor)  
 Indicate the date of exposure  
 Indicate the owner of the 'other'  
 Indicate the address of the 'other'  
 Indicate the species to which exposed  
 Indicate the exposure setting (indoor, outdoor)  
 Indicate the date of exposure  
 Indicate the owner unknown  
 Indicate the address unknown  
 Indicate if species to which exposed unknown  
 Indicate if exposure setting (indoor, outdoor) is unknown  
 Indicate if the date of exposure is unknown  
 Indicate if any other epi linkage (specify)  
 If pet birds, domestic pigeons, or fowl are implicated as the source of the human psittacosis, list address of every known place where the birds were harbored and approx dates.  
  
 Indicate any additional relevant information  
 Indicate what symptoms of interest the patient had during the course of the illness  
  
 Indicator for associated sign and symptom  
 What was the subject's highest measured temperature during this illness?  
 Units for highest measured temperature  
 Did the subject take antibiotics as treatment for this illness?

Start date of antibiotic

Stop date of antibiotic

Number of days the patient actually took the antibiotic

During any part of the hospitalization, did the subject stay in an Intensive Care Unit (ICU) or a Critical Care Unit (CCU)?

Was laboratory testing done to confirm the diagnosis?

Was the case laboratory confirmed?

Test Manufacturer

Type of autopsy specimen

Autopsy result

Date of autopsy (date autopsy specimen collected)

Autopsy Laboratory Name

Industry at date of onset

At the time of exposure, which of the following personal protective equipment was used by the patient?

If respiratory protective equipment was used at the time of exposure, specify what kind

Does the patient get annual respirator fit testing and training?

If gloves were used, specify glove material

Indicate which of the following contacts patient had during 5 weeks prior to onset

What type of bird did the patient have contact with during the 5 weeks prior to onset?

Bird species

Approximate number of birds

Illness onset age

Illness onset age units

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority

|                           |   |
|---------------------------|---|
| PHVS_SignsSymptoms_RIBD   | P |
| PHVS_YesNoUnknown_CDC     | P |
| N/A                       | P |
| PHVS_TemperatureUnit_UCUM | P |
| PHVS_YesNoUnknown_CDC     | P |

|                                          |   |
|------------------------------------------|---|
| N/A                                      | P |
| N/A                                      | P |
| N/A                                      | P |
| PHVS_YesNoUnknown_CDC                    | P |
| PHVS_YesNoUnknown_CDC                    | P |
| PHVS_YesNoUnknown_CDC                    | P |
| N/A                                      | P |
| PHVS_SpecimenSite_RIBD                   | P |
| N/A                                      | P |
| N/A                                      | P |
| N/A                                      | P |
| PHVS_Industry_CDC_Census2010             | P |
| PHVS_PersonalProtectiveEquipment_RIBD    | P |
| PHVS_RespiratoryProtectiveEquipment_RIBD | P |
| PHVS_YesNoUnknown_CDC                    | P |
| PHVS_GloveMaterial_RIBD                  | P |
| PHVS_ContactType_RIBD                    | P |
| PHVS_BirdType_RIBD                       | P |
| N/A                                      | P |
| N/A                                      | P |
| N/A                                      | P |
| PHVS_AgeUnit_UCUM                        | P |

Label/Short Name

Wool or Felt Plant  
Tannery or Rendering  
Dairy  
Veterinarian  
Medical Researcher  
Animal Researcher  
Slaughterhouse  
Laboratory  
Rancher  
Lives in Household

Military  
Other Occupation  
Cattle Contact  
Sheep Contact  
Goat Contact  
Pigeon Contact  
Cat Contact  
Rabbit Contact  
Other Animal Contact

Exposure to Birthing Animals  
Exposure to Unpasteurized Milk  
Milk Animal  
Other Family Ill  
Fever  
Myalgia  
Retro Orbital Pain  
Malaise  
Rash  
Cough  
Headache  
Splenomegaly  
Hepatomegaly  
Pneumonia  
Hepatitis  
Endocarditis  
Other Signs or Symptoms  
Immunocompromised  
Pregnant  
Valvular Disease  
Other Pre-existing Medical Condition

Laboratory Name

Laboratory State

Acute Phase I Serology Collection  
Date

Acute Phase I IFA IgG Result

Acute Phase I IFA IgG Titer

Acute Phase I IFA IgM Result

Acute Phase I IFA IgM Titer

Acute Phase I Compliment Fixation  
Result

Acute Phase I Compliment Fixation  
Titer

Acute Phase I, Other Test Name

Acute Phase I, Other Test Result

Acute Phase I, Other Test Numeric  
Result

Acute Phase II Serology Collection  
Date

Acute Phase II IFA IgG Result

Acute Phase II IFA IgG Titer

Acute Phase II IFA IgM Result

Acute Phase II IFA IgM Titer

Acute Phase II Compliment Fixation  
Result

Acute Phase II Compliment Fixation  
Titer

Acute Phase II, Other Test Name

Acute Phase II, Other Test Result

Acute Phase II, Other Test Numeric  
Result

Convalescent Phase I Serology  
Collection Date

Convalescent Phase I IFA IgG Result

Convalescent Phase I IFA IgG Titer

Convalescent Phase I IFA IgM Result

Convalescent Phase I IFA IgM Titer

Convalescent Phase I Compliment  
Fixation Result

Convalescent Phase I Compliment  
Fixation Titer

Convalescent Phase I, Other Test  
Name

Convalescent Phase I, Other Test  
Result

Convalescent Phase I, Other Test  
Numeric Result

Convalescent Phase II Serology  
Collection Date

Convalescent Phase II IFA IgG Result

Convalescent Phase II IFA IgG Titer  
Convalescent Phase II IFA IgM Result

Convalescent Phase II IFA IgM Titer  
Convalescent Phase II Compliment  
Fixation Result

Convalescent Phase II Compliment  
Fixation Titer

Convalescent Phase II, Other Test  
Name

Convalescent Phase II, Other Test  
Result

Convalescent Phase II, Other Test  
Numeric Result

Fourfold

PCR  
Immunostain

Culture

## Description

Did the case work in a wool or felt plant

Did the case work in a tannery or rendering plant

Did the case work in a dairy

Did the case work as a veterinarian

Did the case work as a medical researcher

Did the case work as an animal researcher

Did the case work in a slaughterhouse

Did the case work in a laboratory

Did the case work as a rancher

Did the case live in a household with someone who may have one of the above occupational exposures

Did the case work in the military

Indicate the case's occupation if none of the above

Did the case have contact with cattle within two months of illness onset

Did the case have contact with sheep within two months of illness onset

Did the case have contact with goats within two months of illness onset

Did the case have contact with pigeons within two months of illness onset

Did the case have contact with cats within two months of illness onset

Did the case have contact with rabbits within two months of illness onset

Indicate any other animals the case had contact with within two months of illness onset

Was the case exposed to birthing animals within two months of illness onset

Was the case exposed to unpasteurized milk within two months of illness onset

If the case was exposed to unpasteurized milk, what animal was the milk from

Was another family member ill with a similar illness within the last year

Did the case report a fever of at least 100.5 during this illness

Did the case report myalgia during this illness

Did the case report retro orbital pain during this illness

Did the case report malaise during this illness

Did the case report a rash during this illness

Did the case report a cough during this illness

Did the case report a headache during this illness

Did the case report splenomegaly during this illness

Did the case report hepatomegaly during this illness

Did the case report pneumonia during this illness

Did the case report hepatitis during this illness

Did the case report endocarditis during this illness

If there were other signs or symptoms reported, the indicate them here

Did the case report a pre-existing immunocompromised system

Was the case pregnant during this illness

Did the case have a pre-existing valvular heart disease or graft

If the case had no other pre-existing medical conditions, then list them here

Indicate the name of the laboratory which supplied results supporting the current CSTE case definitions.

Indicate the state where the laboratory is located

If acute phase I serology was performed, then list the date of collection

If performed, was the acute phase I IFA IgG positive

If performed, what was the reciprocal titer of the acute phase I IFA IgG

If performed, was the acute phase I IFA IgM positive

If performed, what was the reciprocal titer of the acute phase I IFA IgM

If performed, was the acute phase I complement fixation positive

If performed, what was the reciprocal titer of the acute phase I complement fixation

If performed, what was the name of another phase I acute serologic test

If performed, was the other phase I acute serologic test positive

If performed, what was the numeric result of the other phase I acute serologic test

If acute phase II serology was performed, then list the date of collection

If performed, was the acute phase II IFA IgG positive

If performed, what was the reciprocal titer of the acute phase II IFA IgG

If performed, was the acute phase II IFA IgM positive

If performed, what was the reciprocal titer of the acute phase II IFA IgM

If performed, was the acute phase II complement fixation positive

If performed, what was the reciprocal titer of the acute phase II complement fixation

If performed, what was the name of another phase II acute serologic test

If performed, was the other phase II acute serologic test positive

If performed, what was the numeric result of the other phase II acute serologic test

If convalescent phase I serology was performed, then list the date of collection

If performed, was the convalescent phase I IFA IgG positive

If performed, what was the reciprocal titer of the convalescent phase I IFA IgG

If performed, was the convalescent phase I IFA IgM positive

If performed, what was the reciprocal titer of the convalescent phase I IFA IgM

If performed, was the convalescent phase I complement fixation positive

If performed, what was the reciprocal titer of the convalescent phase I complement fixation

If performed, what was the name of another phase I convalescent serologic test

If performed, was the other phase I convalescent serologic test positive

If performed, what was the numeric result of the other phase I convalescent serologic test

If convalescent phase II serology was performed, then list the date of collection

If performed, was the convalescent phase II IFA IgG positive

If performed, what was the reciprocal titer of the convalescent phase II IFA IgG

If performed, was the convalescent phase II IFA IgM positive

If performed, what was the reciprocal titer of the convalescent phase II IFA IgM

If performed, was the convalescent phase II complement fixation positive

If performed, what was the reciprocal titer of the convalescent phase II complement fixation

If performed, what was the name of another phase II convalescent serologic test

If performed, was the other phase II convalescent serologic test positive

If performed, what was the numeric result of the other phase II convalescent serologic test

If paired sera were collected, was there a fourfold change in titer between acute and convalescent of the same phase

If performed, was the polymerase chain reaction assay positive

If performed, were antibodies detected using immunohistochemistry during microscopy

If performed, was the etiologic agent isolated from culture

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
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PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_State\_FIPS\_5-2

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

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PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

Label/Short Name

DAYCARE

FACNAME

NURSHOME

NHNAME

SYNDRM

SPECSYN

SPECIES

OTHBUG1

STERSITE

OTHSTER

DATE

NONSTER

UNDERCOND

COND

OTHMALIG

OTHORGAN

OTHILL

OTHOTHSPC

Specify Internal Body Site

Other Prior Illness 2

Other Prior Illness 3

Other Nonsterile Site

INSURANCE

INSURANCEOTH

WEIGHTLB

WEIGHTOZ

WEIGHTKG

HEIGHTFT

HEIGHTIN

HEIGHTCM

WEIGHTUNK

HEIGHTUNK

SURGERY

SURGDATE

DELIVERY

BABYDATE

GASCOND

## Description

If <6 years of age, is the patient in daycare?

Name of the daycare facility.

Does the patient reside in a nursing home or other chronic care facility?

Name of the nursing home or chronic care facility.

Types of infection that are caused by the organism. This is a multi-select field.

Other infection that is caused by the organism.

Bacterial species that was isolated from any normally sterile site.

Other bacterial species that was isolated from any normally sterile site.

Sterile sites from which the organism was isolated. This is a multi-select field.

Other sterile site from which the organism was isolated.

Date the first positive culture was obtained. (This is considered diagnosis date.)

Nonsterile sites from which the organism was isolated. This is a multi-select field.

Did the patient have any underlying conditions?

Underlying conditions that the subject has. This is a multi-select field.

Other malignancy that the subject had as an underlying condition.

Detail of the organ transplant that the subject had as an underlying condition.

Other prior illness that the subject had as an underlying condition.

Another Bacterial Species not listed in the Other Bacterial Species drop-down list.

Internal Body Site where the organism was located.

Other prior illness that the subject had as an underlying condition.

Other prior illness that the subject had as an underlying condition.

Other nonsterile site from which the organism was isolated.

Patient's type of insurance (multi-selection).

Patient's other type of insurance.

Weight of the patient in pounds.

Weight of the patient in ounces.

Weight of the patient in kilograms.

Height of the patient in feet.

Height of the patient in inches.

Height of the patient in centimeters.

Indicator that the weight of the patient is unknown.

Indicator that the height of the patient is unknown.

Did the patient have surgery?

Date of the surgery

Did the patient have a baby (vaginal or C-section)?

Date of the baby's delivery

Did the patient have other prior conditions? This is a multi-select field.

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

TBD

TBD

TBD

TBD

TBD

PHVS\_YesNoUnknown\_CDC

TBD

TBD

TBD

PHVS\_TrueFalse\_CDC

PHVS\_TrueFalse\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

TBD

Label/Short Name

Did the subject have a rash?

Rash onset date

Duration of rash

Rash Onset occur within 14-23 days  
of entering USA

Did the Subject have a fever?

Highest Measured Temperature

Temperature Units

Date of Fever Onset

Arthralgia/arthritis (symptom)

Lymphadenopathy (symptom)

Conjunctivitis (symptom)

Encephalitis  
(complication)

Thrombocytopenia  
(complication)

Arthralgia/arthritis (complication)

Other Complication

Specify Other Complication

Cause of Death

Was laboratory testing done for  
rubella?

Test Type

Test Result

Sample Analyzed Date

Test Method

Date Collected

Specimen Source

Were the specimens sent to CDC for  
genotyping (molecular typing)?

Specimen type sent to CDC for  
genotyping

Date sent for genotyping

Was Rubella genotype sequenced?

Type of Genotype Sequence

Transmission Setting

Were age and setting verified?

Source of Infection

Is this case Epi-linked to another  
confirmed or probable case?

Traceable to international import?

Expected Delivery Date

Expected Place of Delivery

Number of weeks gestation at time of disease

Trimester of gestation at time of disease

Documentation of previous disease immunity testing

Result of previous immunity testing

Year of previous immunity testing

Age of Subject at time of immunity testing (in years)

Did the Subject ever have this disease prior to this pregnancy?

Was previous disease serologically confirmed?

Year of previous disease

Age of the Subject at time of previous disease (in years)

Current Pregnancy Outcome

At the time of cessation of pregnancy, what was the age of the fetus (in weeks)?

Was an autopsy performed?

Final Anatomical Diagnosis of Death from Autopsy Report

Did the Subject ever receive disease-containing vaccine?

If no, reason subject did not receive a disease-containing vaccine

Number of doses received ON or AFTER first birthday

Vaccine Administered

Vaccine Manufacturer

Vaccine Lot Number

Vaccine Administered Date

US Acquired

Part of Outbreak

Date of Return from Travel  
Case Patient a Healthcare Worker  
Previous case diagnosed by  
Vaccination Doses Prior to Onset  
Date of Last Dose Prior to Illness  
Onset  
Vaccine History Comments  
Age at rash onset  
Age units at rash onset  
Age units at previous diagnosis  
Length of time in U.S.  
Length of time in U.S. Units  
International Destination(s) of  
Recent Travel

## Description

Did the subject being reported in this investigation have a rash?

What was the rash onset date?

How many days did the rash last?

Did rash onset occur 14-23 days after entering USA, following any travel or living outside the USA?

Did the subject have a fever? i.e., a measured temperature >2 degrees above normal

What was the person's highest measured temperature during this illness?

The units of measure of the highest measured temperature. This would be either Fahrenheit or Celsius.

Date of fever onset

Did the Subject have arthralgia/arthritis (symptom)?

Did the Subject have lymphadenopathy (symptom)?

Did the Subject have conjunctivitis (symptom)?

Did the person develop encephalitis as a complication of this illness?

Did the person develop thrombocytopenia as a complication of this illness?

Did Subject have arthralgia/arthritis (complication)?

Did the person develop an other condition(s) as a complication of this illness?

Please specify the other complication(s) the person developed, during or as a result of this illness.

Cause of subject's death

Was laboratory testing done for rubella?

Epidemiologic interpretation of the type of test(s) performed for this case

Epidemiologic interpretation of the results of the tests performed for this case

The date the specimen/isolate was tested

The technique or method used to perform the test and obtain the test results

Date of specimen collection

The medium from which the specimen originated

Were clinical specimens sent to CDC laboratories for genotyping (molecular typing)?

Specimen type sent to CDC for genotyping

The date the specimens were sent to the CDC laboratories for genotyping

Identifies whether the Rubella virus was genotype sequenced.

Identifies the genotype sequence of the Rubella virus

What was the transmission setting where the Rubella was acquired?

Does the age of the case match or make sense for the transmission setting listed (i.e.) a person aged 80 probably would not have a transmission setting of child day care center?

What was the source of the Rubella infection?

Specify if this case is Epidemiologically-linked to another confirmed or probable case of Rubella?

Identifies whether the Rubella case was traceable (linked) to an international import.

What is the expected delivery date of this pregnancy?

Expected place of delivery

Number of weeks gestation at time of rubella disease

Trimester of gestation at time of rubella disease

Is there documentation of previous rubella immunity testing?

Result of previous immunity testing

Year of previous immunity testing

Age of Subject at time of immunity testing

Did the Subject ever have rubella disease prior to this pregnancy?

Was previous rubella disease serologically confirmed?

If previous rubella was serologically confirmed, what was the year of previous disease?

If previous rubella was serologically confirmed, what was the age of the Subject at time of previous disease?

What was the outcome of the current pregnancy?

If applicable, at the time of cessation of pregnancy, what was the age of the fetus (in weeks)?

Was an autopsy performed on the subject's body?

The final anatomical cause of subject's death

Did the Subject ever receive rubella-containing vaccine?

If the subject did not receive a rubella-containing vaccine, what was the reason?

Number of rubella-containing vaccine doses Subject received ON or AFTER first birthday

The type of vaccine administered, (e.g., Varivax, MMRV). First question of a repeating group of vaccine questions.

Manufacturer of the vaccine. Second question of a repeating group of vaccine questions.

The vaccine lot number of the vaccine administered. Third question of a repeating group of vaccine questions.

The date that the vaccine was administered. Fourth question of a repeating group of vaccine questions.

Sub-classification of disease or condition acquired in the US

Is this case part of an outbreak of 3 or more

Date of return from most recent travel

Was the case patient a healthcare provider (HCP) at illness onset?

Who diagnosed previous case?

Number of vaccine doses against this disease prior to illness onset

Date of last vaccine dose against this disease prior to illness onset

Comments about the subject's vaccination history

Age at rash onset

Age units at rash onset

Age units at previous diagnosis

Length of time in U.S.

Length of time in U.S. Units

List any international destinations of recent travel.

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_TemperatureUnit\_UCUM

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_LabTestProcedure\_Rubella

PHVS\_LabTestInterpretation\_VPD

PHVS\_LabTestMethod\_CDC

PHVS\_SpecimenSource\_VPD

PHVS\_YesNoUnknown\_CDC

PHVS\_SpecimenSource\_VPD

PHVS\_YesNoUnknown\_CDC

PHVS\_Genotype\_Rubella

PHVS\_TransmissionSetting\_NND

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_PregnancyTrimester\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_LabTestInterpretation\_VPD

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_BirthOutcome\_Rubella

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_VaccineNotGivenReasons\_CDC

PHVS\_VaccinesAdministeredCVX\_CDC\_NIP

PHVS\_ManufacturersOfVaccinesMVX\_CDC\_NIP

PHVS\_CaseClassificationExposureSource\_NND

| Label/Short Name | Description                                                                                                                                                             |
|------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Formtype         | Type of form reported on<br>(9=carrier form or known carrier)                                                                                                           |
| CDCNUM           | CDC Number                                                                                                                                                              |
| StateEpiNumber   | State Epi Number                                                                                                                                                        |
| SLABSID          | State Lab Isolate ID Number                                                                                                                                             |
| SLABSID2         | State Lab Isolate ID Number<br>2, maybe if another entry is<br>associated in NARMS data                                                                                 |
| SpecNumber       | NARMS Isolate Identification<br>Number                                                                                                                                  |
| SpecNumber2      | NARMS Isolate Identification<br>Number- for duplicate<br>sample from a single patient                                                                                   |
| SpecNumber3      | NARMS Isolate Identification<br>Number- for duplicate<br>sample from a single patient                                                                                   |
| Year             | Year of report (based on date<br>onset)                                                                                                                                 |
| Date Entered     | Date Form was entered into<br>database                                                                                                                                  |
| Date Rec CDC     | Date Form was received to<br>CDC                                                                                                                                        |
| Name             | First three letters of patient's<br>last name                                                                                                                           |
| Foodhand         | Work as foodhandler?<br>(1=Yes, 2=No, 9=unknown<br>3=didn't answer)                                                                                                     |
| Citizen          | Citizen (1=US 2=other<br>9=unknown 3=didn't answer)<br>CSP CHANGED CODE<br>(before, 3=unknown, 9=didn't<br>answer) WAIT to change in<br>SAS                             |
| Othcitzn<br>Ill  | Other citizenship<br>Ill with typhoid fever (1=Yes<br>2=No 9=Unknown 3=didn't<br>answer) CSP CHANGED<br>CODE (before, 3=unknown, 9<br>didn't answer) Changed in<br>SAS! |

|          |                                                                                                                                                   |
|----------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| Dtonset  | Date of onset of Symptoms                                                                                                                         |
| Outcome  | Outcome of case<br>(1=Recovered 2=Died<br>3=didn't answer 9=unknown)                                                                              |
| Dtisol   | Date Salmonella first isolated                                                                                                                    |
| Site     | Sites of isolation (1=Blood<br>2=Stool 3=didn't answer<br>9=unknown 4=gallbladder<br>5=other) CAREFUL with this<br>variable - LOTS of dif. codes! |
| Othsite  | Other site of isolation                                                                                                                           |
| Serotype |                                                                                                                                                   |
| Sensi    | Was sensitivity testing done?<br>(1=Yes 2=No 9=unknown<br>3=didn't answer)                                                                        |
| Ampr     | Resistant to ampicillin on<br>form 3? (1=Yes 2=No 7=not<br>tested 3=didn't answer<br>9=unknown)                                                   |
| Chlorr   | Resistant to chloramphenicol<br>on form 3? (1=Yes 2=No<br>7=not tested 3=didn't<br>answer 9=unknown)                                              |
| Tmpsmxr  | Resistant to trimethoprim-<br>sulfamethoxazole on form 3?<br>(1=Yes 2=No 7=not tested<br>3=didn't answer 9=unknown)                               |
| quinol   | Resistant to fluoroquinolone<br>on form 3? (1=Yes 2=No<br>7=not tested 3=didn't<br>answer 9=unknown)                                              |
| Ceft     | Resistant to ceftriaxone<br>(1=Yes 2=No 9=unknown)                                                                                                |
| outbreak | Case occur as part of<br>outbreak? (1=Yes 2=No<br>9=unknown 3=didn't answer)                                                                      |
| vac5yr   | Vaccinated within 5 yrs?<br>(1=Yes 2=No 9=unknown<br>3=didn't answer)                                                                             |

|             |                                                                                                                 |
|-------------|-----------------------------------------------------------------------------------------------------------------|
| stanvax     | Standard Killed typhoid shot<br>(1=Yes 2=No, 9=unknown,<br>3=didn't answer)                                     |
| yrstanvx    | Year standard vaccine<br>received                                                                               |
| ty21vax     | Oral Ty 21a or Vivotox four<br>pill series (1=Yes 2=No,<br>9=unknown, 3=didn't answer)                          |
| yrty21      | Year of Oral Ty 21a or Vivotox<br>four pill series received                                                     |
| vicps       | VICPS or Typhium VI shot<br>(1=Yes 2=No, 9=unknown,<br>3=didn't answer)                                         |
| yrvicps     | Year VICPS or Typhium VI<br>shot received                                                                       |
| outus       | Travel outside of US? (1=Yes<br>2=No 9=unknown 3=didn't<br>answer)                                              |
| country1    | Country 1 visited                                                                                               |
| country2    | Country 2 visited                                                                                               |
| country3    | Country 3 visited                                                                                               |
| country4    | Country 4 visited                                                                                               |
| country1oth | country 1 other                                                                                                 |
| country2oth | country 2 other                                                                                                 |
| country3oth | country 3 other                                                                                                 |
| country4oth | country 4 other                                                                                                 |
| dtentus     | Date of most return or entry<br>in the US                                                                       |
| business    | Business is purpose of<br>international travel(1=Yes<br>2=No 9=unknown 3=didn't<br>answer)                      |
| tourism     | Tourism is purpose of<br>international travel(1=Yes<br>2=No 9=unknown 3=didn't<br>answer)                       |
| visitfam    | Visiting relatives or friends is<br>purpose of international<br>travel(1=Yes 2=No<br>9=unknown 3=didn't answer) |

|                                          |                                                                                                                                        |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| immigrat                                 | Immigration to the US is purpose of international travel (1=Yes 2=No 9=unknown 3=didn't answer)                                        |
| othtrav                                  | Other travel is purpose of international travel(1=Yes 2=No 9=unknown 3=didn't answer)Reason for other travel                           |
| travreas<br>anycarr                      | Reason for other travel<br>Case traced to typhoid carrier? (1=Yes 2=No 9=unknown 3=didn't answer)                                      |
| prevcarr                                 | Carrier previously known to health dept (1=Yes 2=No 9=unknown 3=didn't answer)                                                         |
| comment<br>dtform                        | Comments<br>Date PH Dept completed form                                                                                                |
| Specify Different Travel Exposure Window | If the travel exposure window used by the jurisdiction is not 30 days. Specify the time interval in days here. Otherwise, leave blank. |
| health care worker                       | Was the patient a health care provider?                                                                                                |
| day care attendee                        | Was the patient a health care attendee?                                                                                                |
| day care worker                          | Was the patient a day care provider?                                                                                                   |
| PulseNet ID                              | State lab ID submitted to PulseNet                                                                                                     |
| WGS ID Number                            | Whole Genome Sequencing (WGS) ID Number                                                                                                |
| Date Of Arrival To Travel Destination    | Date of arrival to travel destination                                                                                                  |
| Travel State                             | Domestic destination, state(s)                                                                                                         |

| Value Set Code. Search in PHIN VADS<br>using the following link<br>( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) | CDC Priority<br>(Legacy) | CDC<br>Priority<br>(New) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|

|     |  |  |
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| N/A |  |  |
|-----|--|--|

|     |   |  |
|-----|---|--|
|     | P |  |
| N/A | P |  |
| N/A | P |  |
| N/A | P |  |
| N/A |   |  |

|     |   |  |
|-----|---|--|
|     | P |  |
| N/A |   |  |
|     | P |  |
| N/A |   |  |

|     |   |  |
|-----|---|--|
|     | P |  |
| N/A |   |  |

|                       |   |  |
|-----------------------|---|--|
|                       | P |  |
| N/A                   |   |  |
|                       | P |  |
| N/A                   |   |  |
|                       | P |  |
| N/A                   |   |  |
|                       | P |  |
| N/A                   |   |  |
|                       | P |  |
| PHVS_YesNoUnknown_CDC |   |  |
|                       | P |  |

|                       |   |  |
|-----------------------|---|--|
|                       | P |  |
| N/A                   | P |  |
| PHVS_YesNoUnknown_CDC |   |  |

|  |   |  |
|--|---|--|
|  | P |  |
|--|---|--|

N/A  
PHVS\_ConditionStatus\_FDD

N/A  
PHVS\_SpecimenCollectionSource\_FDD

N/A  
N/A  
PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

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N/A

P

PHVS\_YesNoUnknown\_CDC

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N/A

P

PHVS\_YesNoUnknown\_CDC

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N/A

P

PHVS\_YesNoUnknown\_CDC

P

PHVS\_Country\_ISO\_3166-1

P

PHVS\_Country\_ISO\_3166-1

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PHVS\_Country\_ISO\_3166-1

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PHVS\_Country\_ISO\_3166-1

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PHVS\_Country\_ISO\_3166-1

P

PHVS\_Country\_ISO\_3166-1

P

N/A

P

PHVS\_TravelPurpose\_FDD

P

PHVS\_TravelPurpose\_FDD

P

PHVS\_TravelPurpose\_FDD

P

PHVS\_TravelPurpose\_FDD

PHVS\_TravelPurpose\_FDD P

N/A P  
P

PHVS\_YesNoUnknown\_CDC P

PHVS\_YesNoUnknown\_CDC P  
N/A P  
N/A  
P  
N/A

P

PHVS\_YesNoUnknown\_CDC P

PHVS\_YesNoUnknown\_CDC P

PHVS\_YesNoUnknown\_CDC P  
N/A 1

N/A 1

N/A 3

PHVS\_State\_FIPS\_5-2 3

| Label/Short Name | Description                                                                                                                        | Value Set Code. Search in PHIN VADS using the following link ( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) |
|------------------|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Formtype         | Type of form reported on (9=carrier form or known carrier)                                                                         |                                                                                                                                                                                |
| CDCNUM           | CDC Number                                                                                                                         |                                                                                                                                                                                |
| StateEpiNumber   | State Epi Number                                                                                                                   |                                                                                                                                                                                |
| SLABSID          | State Lab Isolate ID Number                                                                                                        |                                                                                                                                                                                |
| SLABSID2         | State Lab Isolate ID Number 2, maybe if another entry is associated in NARMS data                                                  |                                                                                                                                                                                |
| SpecNumber       | NARMS Isolate Identification Number                                                                                                |                                                                                                                                                                                |
| SpecNumber2      | NARMS Isolate Identification Number- for duplicate sample from a single patient                                                    |                                                                                                                                                                                |
| SpecNumber3      | NARMS Isolate Identification Number- for duplicate sample from a single patient                                                    |                                                                                                                                                                                |
| Year             | Year of report (based on date onset)                                                                                               |                                                                                                                                                                                |
| Date Entered     | Date Form was entered into database                                                                                                |                                                                                                                                                                                |
| Date Rec CDC     | Date Form was received to CDC                                                                                                      |                                                                                                                                                                                |
| State            | Reporting State                                                                                                                    |                                                                                                                                                                                |
| Name             | First three letters of patient's last name                                                                                         |                                                                                                                                                                                |
| DOB              | Date of Birth                                                                                                                      |                                                                                                                                                                                |
| Age              | Age                                                                                                                                |                                                                                                                                                                                |
| Sex              | Sex (1=Male 2=Female)                                                                                                              |                                                                                                                                                                                |
| Foodhand         | Work as foodhandler? (1=Yes, 2=No, 9=unknown 3=didn't answer)                                                                      |                                                                                                                                                                                |
| Citizen          | Citizen (1=US 2=other 9=unknown 3=didn't answer)<br>CSP CHANGED CODE (before, 3=unknown, 9=didn't answer)<br>WAIT to change in SAS |                                                                                                                                                                                |
| Othcitzn         | Other citizenship                                                                                                                  |                                                                                                                                                                                |

|          |                                                                                                                                       |
|----------|---------------------------------------------------------------------------------------------------------------------------------------|
| Ill      | Ill with typhoid fever (1=Yes 2=No 9=Unknown 3=didn't answer) CSP CHANGED CODE (before, 3=unknown, 9 didn't answer) Changed in SAS!   |
| Dtonset  | Date of onset of Symptoms                                                                                                             |
| Hosp     | Hospitalized? (1=Yes 2=No, 9=unknown, 3=didn't answer)                                                                                |
| Hospdays | Days hospitalized NOTE -- 999= didn't answer in a field like this!                                                                    |
| Outcome  | Outcome of case (1=Recovered 2=Died 3=didn't answer 9=unknown)                                                                        |
| Dtisol   | Date Salmonella first isolated                                                                                                        |
| Site     | Sites of isolation (1=Blood 2=Stool 3=didn't answer 9=unknown 4=gallbladder 5=other) CAREFUL with this variable - LOTS of dif. codes! |
| Othsite  | Other site of isolation                                                                                                               |
| Serotype |                                                                                                                                       |
| Sensi    | Was sensitivity testing done? (1=Yes 2=No 9=unknown 3=didn't answer)                                                                  |
| Ampr     | Resistant to ampicillin on form 3? (1=Yes 2=No 7=not tested 3=didn't answer 9=unknown)                                                |
| Chlorr   | Resistant to chloramphenicol on form 3? (1=Yes 2=No 7=not tested 3=didn't answer 9=unknown)                                           |
| Tmpsmxr  | Resistant to trimethoprim-sulfamethoxazole on form 3? (1=Yes 2=No 7=not tested 3=didn't answer 9=unknown)                             |
| quinol   | Resistant to fluoroquinolone on form 3? (1=Yes 2=No 7=not tested 3=didn't answer 9=unknown)                                           |
| Ceft     | Resistant to ceftriaxone (1=Yes 2=No 9=unknown)                                                                                       |
| outbreak | Case occur as part of outbreak? (1=Yes 2=No 9=unknown 3=didn't answer)                                                                |

|             |                                                                                                        |
|-------------|--------------------------------------------------------------------------------------------------------|
| vac5yr      | Vaccinated within 5 yrs? (1=Yes 2=No 9=unknown 3=didn't answer)                                        |
| stanvax     | Standard Killed typhoid shot (1=Yes 2=No, 9=unknown, 3=didn't answer)                                  |
| yrstanvx    | Year standard vaccine received                                                                         |
| ty21vax     | Oral Ty 21a or Vivotof four pill series (1=Yes 2=No, 9=unknown, 3=didn't answer)                       |
| yrty21      | Year of Oral Ty 21a or Vivotof four pill series received                                               |
| vicps       | VICPS or Typhium VI shot (1=Yes 2=No, 9=unknown, 3=didn't answer)                                      |
| yrvicps     | Year VICPS or Typhium VI shot received                                                                 |
| outus       | Travel outside of US? (1=Yes 2=No 9=unknown 3=didn't answer)                                           |
| country1    | Country 1 visited                                                                                      |
| country2    | Country 2 visited                                                                                      |
| country3    | Country 3 visited                                                                                      |
| country4    | Country 4 visited                                                                                      |
| country1oth | country 1 other                                                                                        |
| country2oth | country 2 other                                                                                        |
| country3oth | country 3 other                                                                                        |
| country4oth | country 4 other                                                                                        |
| dtentus     | Date of most return or entry in the US                                                                 |
| business    | Business is purpose of international travel(1=Yes 2=No 9=unknown 3=didn't answer)                      |
| tourism     | Tourism is purpose of international travel(1=Yes 2=No 9=unknown 3=didn't answer)                       |
| visitfam    | Visiting relatives or friends is purpose of international travel(1=Yes 2=No 9=unknown 3=didn't answer) |
| immigrat    | Immigration to the US is purpose of international travel (1=Yes 2=No 9=unknown 3=didn't answer)        |

|                                          |                                                                                                                                        |                       |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| othtrav                                  | Other travel is purpose of international travel(1=Yes 2=No 9=unknown 3=didn't answer)Reason for other travel                           |                       |
| travreas                                 | Reason for other travel                                                                                                                |                       |
| anycarr                                  | Case traced to typhoid carrier? (1=Yes 2=No 9=unknown 3=didn't answer)                                                                 |                       |
| prevcarr                                 | Carrier previously known to health dept (1=Yes 2=No 9=unknown 3=didn't answer)                                                         |                       |
| comment                                  | Comments                                                                                                                               |                       |
| dtform                                   | Date PH Dept completed form                                                                                                            |                       |
| Specify Different Travel Exposure Window | If the travel exposure window used by the jurisdiction is not 30 days. Specify the time interval in days here. Otherwise, leave blank. | N/A                   |
| health care worker                       | Was the patient a health care provider?                                                                                                | PHVS_YesNoUnknown_CDC |
| day care attendee                        | Was the patient a health care attendee?                                                                                                | PHVS_YesNoUnknown_CDC |
| day care worker                          | Was the patient a day care provider?                                                                                                   | PHVS_YesNoUnknown_CDC |
| PulseNet ID                              | State lab ID submitted to PulseNet                                                                                                     | N/A                   |
| WGS ID Number                            | Whole Genome Sequencing (WGS) ID Number                                                                                                | N/A                   |
| Date Of Arrival To Travel Destination    | Date of arrival to travel destination                                                                                                  | N/A                   |
| Travel State                             | Domestic destination, state(s) tr                                                                                                      | PHVS_State_FIPS_5-2   |

CDC Priority  
(Legacy)

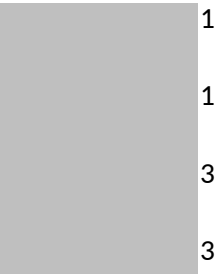
CDC  
Priority  
(New)

P

P

P

P



Label/Short Name

AgClinic

AgClinicTestType

AgeMnth

AgeYr

AgSphl

AgSphlTestType

Biold

BloodyDiarr

Diarrhea

DtAdmit2

DtDisch2

DtEntered

DtRcvd

DtRptComp

DtSpec

DtUSDepart

DtUSReturn

EforsNum

Fever

HospTrans

Immigrate

Interview

LabName

LocalID

OtherCdcTest

OtherClinicTest

OtherClinicTestType

OtherSphlTest

OtherSphlTestType

OutbrkType

PatID

PcrCdc

PcrClinic

PcrClinicTestType

PcrSphl

PersonID

ResultID  
RptComp  
SalGroup  
SentCDC  
SeroSite  
SLabsID  
SpecSite  
StLabRcvd

TravelDest  
TravelInt  
Dom\_travel

Out\_freq

Chx\_handle

Chicken

Chx\_uncook

chx\_ground  
Chx\_whole

chx\_processed

Chx\_outside

Chx\_home

Chx\_fresh  
Chx\_frozen  
Turkey\_handle

Turkey

Turkey\_uncook

Turkey\_ground  
Turkey\_whole

Turkey\_processed

Turkey\_outside

Turkey\_home

Other\_poultry

Beef\_handle

Beef

Beef\_uncook

Beef\_ground

Beef\_whole

Beef\_processed

Beef\_outside

Beef\_home

Beef\_fresh

Beef\_frozen

Pork\_handle

Pork

Pork\_uncook

Pork\_whole

Pork\_processed

Lamb

Seafood

seafood\_uncook

Fish

Fish\_uncook

Fish\_whole

Eggs

Eggs\_outside

Eggs\_home

Eggs\_uncook

Dairy

Queso\_fresco

Dairy\_uncook

Cantaloupe

Strawberries

Other\_berries

Watermelon

Apples

Honeydew

Pineapple

Raw\_cider

Other\_fruit

Nuts\_uncook

Lettuce

Cabbage

Spinach

Broccoli

Tomatoes

Onions

Carrots

Sprouts

Herbs

Other\_veggies

Infant\_formula

Infant\_bmilk

Infant\_omilk

Well\_water

Other\_untreated

Swim\_unchlor

Sick\_contacts

Diaper\_contact

Shared\_facility

Daycare

Sick\_pet

Reptile\_amphib

Outdoors

Manure\_compost

Farm\_ranch

Live\_poultry

Cattle\_others

Other\_animals

Site ID

Disease

State Lab ID

Collection Date

Last Updated

Confirmed

Specimen Source

Test Result

Occupation/Industry/Place of  
Business

Child care attendee

Long term care facility resident

Contact of a Salmonellosis case

Method(s) of laboratory testing

Name of test

Name of test manufacturer

Probable case from CDT testing

Probable case from Epi-linkage

Reported symptoms and signs of illness

WGS (Whole-Genome Sequencing)  
ID

Specify Different Travel Exposure  
Window

PulseNet ID

Date Of Arrival To Travel Destination

Date Of Departure From Travel  
Destination

Reason for travel related to current  
illness

## Description

What was the result of specimen testing using an antigen-based test (e.g. EIA or lateral flow) at a clinical laboratory?

Name of antigen-based test used at clinical laboratory

Age of case-patient in months if patient is <1yr

Age of case-patient in years

What was the result of specimen testing using an antigen-based test (e.g. EIA or lateral flow) at a state public health laboratory?

Name of antigen-based test used at state public health laboratory

Was the pathogen identified by culture?

Did the case-patient have bloody diarrhea (self reported) during this illness?

Did the case-patient have diarrhea (self-reported) during this illness?

Date of hospital admission for second hospitalization for this illness

Date of hospital discharge for second hospitalization for this illness

Date case was entered into site's database

Date case-patient's specimen was received in laboratory for initial testing

Date case report form was completed

Case-patient's specimen collection date

If case-patient traveled internationally, date of departure from the U.S.

If case-patient traveled internationally, date of return to the U.S.

CDC FDOSS outbreak ID number

Did the case-patient have fever (self-reported) during this illness?

If case-patient was hospitalized, was s/he transferred to another hospital?

Did case-patient immigrate to the U.S.? (within 7 days of illness onset)

Was the case-patient interviewed by public health (i.e. state or local health department) ?

Name of submitting laboratory

Case-patient's medical record number

What was the result of specimen testing using another test at CDC?

What was the result of specimen testing using another test at a clinical laboratory?

Name of other test used at a clinical laboratory

What was the result of specimen testing using another test at a state public health laboratory?

Name of other test used at a state public health laboratory

Type of outbreak that the case-patient was part of

Case-patient identification number

What was the result of specimen testing for diagnosis using PCR at CDC? (Do not enter PCR results if PCR was performed for speciation or subtyping).

What was the result of specimen testing using PCR at a clinical laboratory? (where goal of testing is primary detection not subtyping or speciation)

Name of PCR assay used

What was the result of specimen testing for diagnosis using PCR at the state public health laboratory? (Do not enter PCR results if PCR was performed for speciation or subtyping).

Unique identification number for person or patient

Unique identifier for laboratory result

Is all of the information for this case complete?

Salmonella serogroup

Was specimen or isolate forwarded to CDC for testing or confirmation?

Serotype/species of pathogen

State lab identification number

Case patient's specimen collection source

Was the isolate sent to a state public health laboratory? (Answer 'Yes' if it was sent to any state lab, even if it was sent to a lab outside of the case's state of residence)

If case-patient traveled internationally, to where did they travel?

Did the case patient travel internationally? (within 7 days of onset)

In the 7 days before illness, would you/your child have traveled within the US but outside of the area where you live or work?

How many times would you/your child have eaten out (deli, fast food, or other restaurant)?

Would you/your child, or anyone in your household, have handled raw chicken in the home?

How many times would you/your child have eaten chicken or any foods containing chicken?

In the 7 days before illness, would you/your child have eaten any chicken that was raw or undercooked?

In the 7 days before illness, would you/your child have eaten any ground chicken?

In the 7 days before illness, would you/your child have eaten any whole or cut chicken parts (e.g., rotisserie, chicken breasts, wings, etc.)?

In the 7 days before illness, would you/your child have eaten any processed chicken (e.g., deli meat, chicken nuggets, pre-made dinners, etc.)?

In the 7 days before illness, would you/your child have eaten any chicken made outside of home (deli, fast food, take-out, or restaurant)?\*\*

In the 7 days before illness, would you/your child have eaten any chicken made at home?

Was the chicken bought fresh (refrigerated)? (Answer if Yes to Q56)

Was the chicken bought frozen? (Answer if Yes to Q56)

Would you/your child, or anyone in your household, have handled raw turkey in the home?

In the 7 days before illness, would you/your child have eaten any turkey or any foods containing turkey?

In the 7 days before illness, would you/your child have eaten any turkey that was undercooked or raw?

In the 7 days before illness, would you/your child have eaten any ground turkey?

In the 7 days before illness, would you/your child have eaten any whole or cut turkey parts?

In the 7 days before illness, would you/your child have eaten any processed turkey (e.g., deli meat, bacon, sausage, pre-made dinners, etc.)?\*\*

In the 7 days before illness, would you/your child have eaten any turkey made outside of home (deli, fast food, take-out, or restaurant)?

In the 7 days before illness, would you/your child have eaten any turkey made at home?

In the 7 days before illness, would you/your child have eaten any poultry other than chicken or turkey (e.g., duck, cornish hens, quail, etc.)?

Would you/your child, or anyone in household, have handled raw beef in the home?

In the 7 days before illness, would you/your child have eaten beef or any foods containing beef?

In the 7 days before illness, would you/your child have eaten any beef that was undercooked or raw?

In the 7 days before illness, would you/your child have eaten any ground beef?

In the 7 days before illness, would you/your child have eaten any whole or cut beef parts (e.g., steaks, roasts, etc.)?

In the 7 days before illness, would you/your child have eaten any processed beef (e.g., deli meat, sausage, jerky, pre-made dinners, etc.)?

In the 7 days before illness, would you/your child have eaten any beef made outside of home (deli, fast food, take-out, or restaurant)?

In the 7 days before illness, would you/your child have eaten any beef made at home?

Was the beef bought fresh (refrigerated)? (Answer if Yes to Q75)

Was the beef bought frozen? (Answer if Yes to Q75)

Would you/your child, or anyone in your household, have handled raw pork in the home?

In the 7 days before illness, would you/your child have eaten pork or any foods containing pork?

In the 7 days before illness, would you/your child have eaten any undercooked or raw pork?

In the 7 days before illness, would you/your child have eaten any whole or cut pork parts (e.g., ham shank, pork chops, chitlins, etc.)?

In the 7 days before illness, would you/your child have eaten any processed pork (e.g., deli meat [like ham slices], bacon, sausage, etc.)? \*\*

In the 7 days before illness, would you/your child have eaten any lamb?

In the 7 days before illness, would you/your child have eaten any non-fish seafood (e.g., crab, shrimp, oysters, clams, etc.) that was not from a can?

In the 7 days before illness, would you/your child have eaten any non-fish seafood that was undercooked or raw (e.g., raw oysters, clams, etc.)?

In the 7 days before illness, would you/your child have eaten any fish or fish products (processed or unprocessed) that was not from a can?

In the 7 days before illness, would you/your child have eaten any fish that was undercooked or raw (e.g., sushi, etc.)?

In the 7 days before illness, would you/your child have eaten any whole fish or fish filets (unprocessed fish)?

In the 7 days before illness, would you/your child have eaten eggs or any foods containing eggs?

In the 7 days before illness, would you/your child have eaten any eggs made away outside of home (deli, fast food, take-out, or restaurant)? \*\*

In the 7 days before illness, would you/your child have eaten any eggs made at home?

In the 7 days before illness, would you/your child have eaten any eggs that were runny or raw, or uncooked foods made with raw eggs?

In the 7 days before illness, would you/your child have eaten or drank any dairy products (e.g., milk, yogurt, cheese, ice cream, etc.)?

In the 7 days before illness, would you/your child have eaten any queso fresco, queso blanco, or other type of Mexican-style soft cheese?

...eaten or drank any dairy products that were raw or unpasteurized (e.g., raw milk, or cheeses, yogurts, and ice cream made from raw milk)?

In the 7 days before illness, would you/your child have eaten any fresh cantaloupe?

In the 7 days before illness, would you/your child have eaten any fresh (unfrozen) strawberries?

In the 7 days before illness, would you/your child have eaten any other fresh (unfrozen) berries?

In the 7 days before illness, would you/your child have eaten any fresh watermelon?

In the 7 days before illness, would you/your child have eaten any fresh apples?

In the 7 days before illness, would you/your child have eaten any fresh honeydew melon?

In the 7 days before illness, would you/your child have eaten any fresh pineapple?

In the 7 days before illness, would you/your child have drank any unpasteurized juice or cider?

In the 7 days before illness, would you/your child have eaten any other fruit (fresh or frozen) or drank other fruit juices?

In the 7 days before illness, would you/your child have eaten any raw or uncooked nuts?

In the 7 days before illness, would you/your child have eaten any fresh, raw lettuce?

In the 7 days before illness, would you/your child have eaten any fresh, raw cabbage?

In the 7 days before illness, would you/your child have eaten any fresh (unfrozen), raw spinach?

In the 7 days before illness, would you/your child have eaten any fresh (unfrozen), raw broccoli?

In the 7 days before illness, would you/your child have eaten any fresh, raw tomatoes?

In the 7 days before illness, would you/your child have eaten any fresh (unfrozen), raw onions?

In the 7 days before illness, would you/your child have eaten any fresh (unfrozen), raw carrots?

In the 7 days before illness, would you/your child have eaten any fresh, raw sprouts?

In the 7 days before illness, would you/your child have eaten any fresh (not dried) herbs?

In the 7 days before illness, would you/your child have eaten any other vegetables (fresh or frozen) or drank any vegetable juices?

If you are answering for an ill infant aged 1 year or younger, are they drinking infant formula?

If you are answering for an ill infant aged 1 year or younger, are they drinking breast milk?

If you are answering for an ill infant aged 1 year or younger, are they drinking any other milk?

In the 7 days before illness, would you/your child have drank any water from a well?

In the 7 days before illness, would you/your child have swallowed or drank any water directly from a natural spring, lake, pond, stream, or river?

In the 7 days before illness, would you/your child have swam in, waded in, or entered an ocean, lake, pond, river, stream, or natural spring?

Was there a household member or a close contact with diarrhea?

In the 7 days before illness, would you/your child have had contact with dirty diapers?

In the 7 days before illness, would you/your child have lived, worked, or volunteered in a shared living facility (e.g., dorm, nursing home, etc.)?

Would you/your child, or anyone in your house, have attended, worked, or volunteered at a day care?

In the 7 days before illness, would you/your child have had any contact with a pet that had diarrhea?

In the 7 days before illness, would you/your child have had any contact with a reptile or amphibian (e.g., frog, snake, turtle, etc.)?

In the 7 days before illness, would you/your child have done any hiking, camping, gardening, or yard work?

In the 7 days before illness, would you/your child have had any contact with animal manure, pet feces, or compost?

In the 7 days before illness, would you/your child have visited, worked, or lived on farm, ranch, petting zoo, or other setting that has farm animals?

Were there any live poultry (e.g., chickens, turkeys, hens, etc.)? (Answer if Yes to Q130)

Were there any cattle, goats, or sheep? (Answer if Yes to Q130)

Were there any other farm animals (e.g., pigs, horses, etc.)? (Answer if Yes to Q130)

Site ID assigned by CDC.

Foodborne Disease.

Identification of Isolate

Date isolate taken from patient

Date of Last Modification

Is isolate confirmed

Source of isolate

Serotype/Species/Test Result

Is patient employed in a high risk occupation (e.g., food handler, healthcare worker, daycare worker)?

Did patient have a high risk exposure related to child care facility?

Did patient have a high risk exposure related to residence in a long term care facility?

Did patient have a high risk exposure related to contact with a Salmonellosis case?

Type of laboratory testing performed

Name of laboratory test performed

Name of test manufacturer

Probable case status confirmed by CDT testing

Probable case confirmed by Epi-linkage

Symptoms and signs associated with illness

The identifier used in PulseNet for the whole genome sequenced isolate that corresponds to the reported case

If the travel exposure window used by the jurisdiction is different from that stated in the travel exposure questions, specify the time interval in days here. Otherwise, leave blank.

State lab ID submitted to PulseNet

Date of arrival to travel destination

Date of departure from travel destination

Reason for travel related to current illness

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

| CDC Priority<br>(Legacy) | CDC Priority<br>(New) |
|--------------------------|-----------------------|
|--------------------------|-----------------------|

N/A

P

N/A

N/A

N/A

PHVS\_TravelPurpose\_FDD

|  |   |
|--|---|
|  | 1 |
|  | 3 |
|  | 3 |
|  | 3 |

Label/Short Name

Fever

Fever date

Temperature >38°C(100.4°F)

Lower respiratory symptoms

Chest x-ray/CAT scan

Pneumonia/RDS evidence

Evaluation first date

Hospitalization

Hospital name

Hospital city

Hospital state

Hospitalization date

Discharge date

ICU admission

Mechanical ventilation

Death

Death date

Autopsy

Pathology results

HCW

HCW type

Direct patient care

Occupation

Case contact

RUI-2 or RUI-3 contact

Travel to SARS area

Travel destination

Contact classification

Nature of contact

Contact start

Contact end

Contact travel to SARS area

Contact CDC ID

Contact State ID

Contact name

Foreign travel Health Alert

Symptomatic during travel for a SARS  
area

SARS suspect name

Public conveyance travel departure

Public conveyance travel departure  
city

Public conveyance travel arrival city

Public conveyance transport type

Transport company

Transport number

Comment

Initial patient classification

Updated patient classification

Date updated

Laboratory Specimen 1

Lab specimen 1 collection date

Lab specimen 1 test

Lab specimen 1 source of local  
testing

Lab specimen 1 result

Laboratory Specimen 2

Lab specimen 2 collection date

Lab specimen 2 test

Lab specimen 2 source of local  
testing

Lab specimen 2 result

Laboratory Specimen 3

Lab specimen 3 collection date

Lab specimen 3 test

Lab specimen 3 source of local  
testing

Lab specimen 3 result

Laboratory Specimen 4

Lab specimen 4 collection date

Lab specimen 4 test

Lab specimen 4 source of local testing

Lab specimen 4 result

Laboratory Specimen 5

Lab specimen 5 collection date

Lab specimen 5 test

Lab specimen 5 source of local testing

Lab specimen 5 result

Laboratory Specimen 6

Lab specimen 6 collection date

Lab 6 test

Lab specimen 6 source of local testing

Lab specimen 6 result

Laboratory Specimen 7

Lab specimen 7 collection date

Lab 7 test

Lab specimen 7 source of local testing

Lab specimen 7 result

Laboratory Specimen 8

Lab specimen 8 collection date

Lab 8 test

Lab specimen 8 source of local testing

Lab specimen 8 result

Alternative Diagnosis

Alternative pathogen

CDC Specimen 1

Tissue specimen 1

CDC specimen 1 date

CDC Specimen 2

Tissue specimen 2

CDC specimen 2 date

CDC Specimen 3

Tissue specimen 3

CDC specimen 3 date

CDC Specimen 4

Tissue specimen 4  
CDC specimen 4 date  
CDC Specimen 5  
Tissue specimen 5  
CDC specimen 5 date  
CDC Specimen 6  
Tissue specimen 6  
CDC specimen 6 date  
CDC Specimen 7  
Tissue specimen 7  
CDC specimen 7 date  
CDC Specimen 8  
Tissue specimen 8  
CDC specimen 8 date  
Notes

## Description

Did the patient have a fever (subjective or objective)?

If yes, date of fever onset

Was the measured temperature  $>38^{\circ}\text{C}$ ?

Did the patient have any lower respiratory symptoms (e.g., a cough, shortness of breath, difficulty breathing)?

Was a chest x-ray or CAT scan performed?

If yes, did the patient have radiographic evidence of pneumonia or respiratory distress syndrome?

Indicate date of the first evaluation for this illness.

Was patient hospitalized for  $>24$  hours during the course?

If yes, indicate the name of the hospital

If yes, indicate the city of the hospital

If yes, indicate the state of the hospital

Indicate date of hospitalization

Indicate date of hospital discharge

Was the patient ever admitted to the intensive care unit (ICU)?

Was the patient ever placed on mechanical ventilation?

Did the patient die as a result of his /her illness?

Indicate date of death

Was an autopsy performed?

Was pathology consistent with pneumonia or RDS?

Is the patient a healthcare worker?

If so, indicate type of HCW (physician, nurse/PA, lab, other [specify])

Does patient have DIRECT patient care responsibilities?

If not a HCW, list occupation.

In the 10 days prior to symptom onset did the patient have close contact with a confirmed or probable SARS-CoV case?

In the 10 days prior to symptom onset did the patient have close contact with a person considered an RUI-2 or RUI-3?

In the 10 days prior to symptom onset did the patient have travel to foreign or domestic area with documented or suspected recent local transmission of SARS cases?

If yes, list travel destinations (departure and arrival dates).

Classification of contact (RUI-2w, RUI-3, probable SARS-CoV, confirmed SARS-CoV).

Nature of contact (same household, coworker, HC environment, other).

Date contact started

Date contact ended

Did the ill contact recently travel to an area with SARS transmission (specify where)?

Contact CDC ID

Contact State ID

If CDC ID or State ID unavailable ((first, middle initial, last)

If recent foreign travel, did the patient receive a health Alert or other SARS educational information on arrival in the U.S?

Was the patient symptomatic during the travel from a SARS affected area within 24 hours of return to the U.S or local area?

If yes, provide to the CDC the name of the SARS suspect who has traveled (enter name)

If yes, indicate public conveyance departure date

If yes, indicate public conveyance departure city

If yes, indicate public conveyance arrival city

Public conveyance transport type (airline, train, cruise, bus, auto, tour grp, other)

Name of transport company

Indicate transport number

Patient's initial classification by state of municipality (RUI-1, RUI-2, RUI-3, RUI-4, or probable SARS-CoV, confirmed SARS-CoV)

Patient's updated classification( RUI-1, RUI-2, RUI-3, RUI-4, probable SARS-CoV, confirmed SARS-CoV, not a case: negative serology, not a case: alternative diagnosis accounts for illness)

Most recent updated classification

Enter specimen for each test (whole blood, serum [acute and/or convalescent], NP swab, NP aspirate, bronchoalveolar lavage, OP swab, urine, stool, tissue [specify tissue type])

Collection date for specimen 1

Test requested for specimen 1

Source of local testing for specimen 1

Result of lab testing for specimen 2

Enter specimen for each test (whole blood, serum [acute and/or convalescent], NP swab, NP aspirate, bronchoalveolar lavage, OP swab, urine, stool, tissue [specify tissue type])

Collection date for specimen 2

Test requested for specimen 2

Source of local testing for specimen 2

Result of lab testing for specimen 2

Enter specimen for each test (whole blood, serum [acute and/or convalescent], NP swab, NP aspirate, bronchoalveolar lavage, OP swab, urine, stool, tissue [specify tissue type])

Collection date for specimen 3

Test requested for specimen 3

Source of local testing for specimen 3

Result of lab testing for specimen 3

Enter specimen for each test (whole blood, serum [acute and/or convalescent], NP swab, NP aspirate, bronchoalveolar lavage, OP swab, urine, stool, tissue [specify tissue type])

Collection date for specimen 4

Test requested for specimen 4

Source of local testing for specimen 4

Result of lab testing for specimen 4

Enter specimen for each test (whole blood, serum [acute and/or convalescent], NP swab, NP aspirate, bronchoalveolar lavage, OP swab, urine, stool, tissue [specify tissue type])

Collection date for specimen 5

Test requested for specimen 5

Source of local testing for specimen 5

Result of lab testing for specimen 5

Enter specimen for each test (whole blood, serum [acute and/or convalescent], NP swab, NP aspirate, bronchoalveolar lavage, OP swab, urine, stool, tissue [specify tissue type])

Collection date for specimen 6

Test requested for specimen 6

Source of local testing for specimen 6

Result of lab testing for specimen 6

Enter specimen for each test (whole blood, serum [acute and/or convalescent], NP swab, NP aspirate, bronchoalveolar lavage, OP swab, urine, stool, tissue [specify tissue type])

Collection date for specimen 7

Test requested for specimen 7

Source of local testing for specimen 7

Result of lab testing for specimen 7

Enter specimen for each test (whole blood, serum [acute and/or convalescent], NP swab, NP aspirate, bronchoalveolar lavage, OP swab, urine, stool, tissue [specify tissue type])

Collection date for specimen 8

Test requested for specimen 8

Source of local testing for specimen 8

Result of lab testing for specimen 8

Was an alternative respiratory pathogen detected?

If yes, indicate the pathogen isolated.

List specimen(s) sent to CDC

If 'tissue', specify.

Date specimen 1 sent to CDC

List specimen(s) sent to CDC

If 'tissue', specify.

Date specimen 2 sent to CDC

List specimen(s) sent to CDC

If 'tissue', specify.

Date specimen 3 sent to CDC

List specimen(s) sent to CDC

If 'tissue', specify.

Date specimen 4 sent to CDC

List specimen(s) sent to CDC

If 'tissue', specify.

Date specimen 5 sent to CDC

List specimen(s) sent to CDC

If 'tissue', specify.

Date specimen 6 sent to CDC

List specimen(s) sent to CDC

If 'tissue', specify.

Date specimen 7 sent to CDC

List specimen(s) sent to CDC

If 'tissue', specify.

Date specimen 8 sent to CDC

Any notes needed

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

Label/Short Name

Site ID

Disease

State Lab ID

Collection Date

Last Updated

Confirmed

Specimen Source

Test Result

International travel in the 7 days  
prior to onset

Occupation/Industry/Place of  
Business

Child care attendee

Long term care facility resident

Contact of a Shigellosis case

Method(s) of laboratory testing

Name of test

Name of test manufacturer

Probable case from CIDT

Probable case from Epi-linkage

Reported symptoms and signs of  
illness

WGS (Whole-Genome Sequencing)  
ID

Specify Different Travel Exposure  
Window

Did The Case Travel Domestically  
Prior To Illness Onset?

Travel State

International Destination(S) Of  
Recent Travel

PulseNet ID

Date Of Arrival To Travel Destination

Date Of Departure From Travel  
Destination

Reason for travel related to current  
illness

## Description

Site ID assigned by CDC.

Foodborne Disease.

Identification of Isolate

Date isolate taken from patient

Date of Last Modification

Is isolate confirmed

Source of isolate

Serotype/Species/Test Result

Did patient travel internationally within 7 days of illness onset?

Is patient employed in a high risk occupation (e.g., food handler, healthcare worker, daycare worker)?

Did patient have a high risk exposure related to attendance at a child care facility?

Did patient have a high risk exposure related to residence in a long term care facility?

Did patient have a high risk exposure related to contact with a Shigellosis case?

Type of laboratory testing performed

Name of laboratory test performed

Name of test manufacturer

Probable case status confirmed by CIDT (Culture Independent Diagnostic Testing)

Probable case confirmed by Epi-linkage

Symptoms and signs associated with illness

The identifier used in PulseNet for the whole genome sequenced isolate that corresponds to the reported case

If the travel exposure window used by the jurisdiction is different from that stated in the travel exposure questions, specify the time interval in days here. Otherwise, leave blank.

Did the case patient travel domestically within program specific timeframe?

Domestic destination, state(s) traveled to

International destination or countries the patient traveled to

State lab ID submitted to PulseNet

Date of arrival to travel destination

Date of departure from travel destination

Reason for travel related to current illness

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

N/A

P

PHVS\_YesNoUnknown\_CDC

P

PHVS\_State\_FIPS\_5-2

P

PHVS\_Country\_ISO\_3166-1

P

N/A

N/A

N/A

PHVS\_TravelPurpose\_FDD



CDC Priority (New)

- 1
- 2
- 2
- 3

Label/Short Name

Notification ID

Receiving Application

Message Profile ID

Local Subject ID

Subject Name Type

Local Record ID

Subject Type

Notification Type

Date First Submitted

Date of Report

Notification Result Status

Immediate National Notifiable  
Condition

Reporting State

Reporting County

National Reporting Jurisdiction

Condition Code

Birth Date

Subject's Sex

Race Category

Subject Address County

Subject Address State

Subject Address ZIP Code

Ethnic Group Code

Country of Birth

Census tract of case-patient  
residence

Country of Usual Residence

Jurisdiction Code  
Case Investigation Status Code  
Investigation Date Assigned  
Date of Report/Referral

Reporting Source Type Code

Reporting Source ZIP Code  
Earliest Date Reported to County  
Earliest Date Reported to State  
Hospitalized  
Admission Date

Discharge Date

Duration of hospital stay in days

Diagnosis Date  
Date of Illness Onset

Illness End Date  
Illness Duration  
Illness Duration Units  
Did the subject die from this  
condition?  
Deceased Date

Case Investigation Start Date  
Case Outbreak indicator  
Case Outbreak Name  
Case Disease Imported Code  
Imported Country

Imported State

Imported City

Imported County

Transmission Mode

Case Class Status Code

MMWR Week

MMWR Year

State Case ID

Date of First Report to CDC

Date First Reported PHD

Pregnancy status

Person Reporting to CDC - Name

Person Reporting to CDC - Phone  
Number

Person Reporting to CDC - Title

Person Reporting to CDC - Affiliation

Legacy Case ID

Age at case investigation

Age units at case investigation

Country of Exposure or Country  
Where Disease was Acquired

Note: use exposure or acquired  
consistently across variables

State or Province of Exposure

City of Exposure

## County of Exposure

### Binational Reporting Criteria

Date of initial health exam  
associated with case report "health  
event"

Neurological involvement?

Treatment Date

HIV Status

Had sex with a male within past 12  
months?

Had sex with a female within past 12  
months?

Had sex with an anonymous partner  
within past 12 months?

Had sex with a person know to  
him/her to be an IDU within past 12  
months?

Had sex while intoxicated and/or  
high on drugs within past 12  
months?

Exchanged drugs/money for sex  
within past 12 months?

Had sex with a person who is know  
to her to be an MSM within past 12  
months?

Engaged in injection drug use within  
past 12 months?

During the past 12 months, which of  
the following injection or non-  
injection drugs have been used?

Previous STD history?

Been incarcerated with past 12  
months?

Have you met sex partners through  
the Internet in the last 12 months?

Total number of sex partners last 12  
months?

Clinician-observed lesion(s)  
indicative of syphilis

Type of nontreponemal serologic  
test for syphilis

Quantitative syphilis test result

Patient refused to answer questions  
regarding number of sex partners

Unknown number of sex partners in  
last 12 months

Date of laboratory specimen  
collection

Specimen source

Date of lab result

HIV status documented through  
eHARS Record Search?

eHARS Stateno

Trans\_Categ (eHARS, person dataset)

Case sampled for enhanced  
investigation?

Method of case detection

Type of treponemal serologic test for  
syphilis

Count

Event date

Datatype

NETSS version

STD-Associated Lab Tests

STD-Associated Lab Results

Injection or non-injection drugs use  
indicator

Nontreponemal serologic syphilis  
test (quantitative)

Nontreponemal serologic syphilis  
test (qualitative)

Qualitative treponemal serologic  
syphilis test result

Neurological manifestations  
Ocular Manifestations

Otic Manifestations

Late Clinical Manifestations (tertiary  
syphilis)

Transgender

Sexual Orientation

Date Treatment was Prescribed  
Date Treatment was Administered  
Medication Administered  
Medication Administered Dose  
Treatment Duration  
Type of Complication  
Type of Complication Indicator  
Treatment Dosage  
Treatment Dosage Unit  
Treatment Route of Delivery  
Treatment Drug Frequency  
Treatment Drug Frequency Unit  
Treatment Duration Units  
Drug Use Route of Delivery  
Birth Sex

Sexual Orientation

Gender Identity

## Description

The unique identifier for the notification record

CDC's PHIN Common Data Store (CDS) is the Receiving Application for this message.

First instance is the reference to the structural specification used to validate the message.

Second instance is the reference to the PHIN Message Mapping Guide from which the content is derived.

The local ID of the subject/entity.

Name is not requested by the program, but the Patient Name field is required to be populated for the HL7 message to be valid. Have adopted the HL7 convention for processing a field where the name has been removed for de-identification purposes.

Sending system-assigned local ID of the case investigation with which the subject is associated.

Note: The local record ID should be the unique identifier for the case being reported.

Type of subject for the notification. "Person," "Place/Location," or "Non-Person Living Subject" are the appropriate subject types for Notifications to CDC.

Type of notification. Notification types are "Individual Case," "Environmental," "Summary," and "Laboratory Report".

Date/time the notification was first sent to CDC. This value does not change after the original notification.

Date/time this version of the notification was sent. It will be the same value as NOT103 for the original notification. For updates, this is the update/send date/time.

Status of the notification.

Does this case meet the criteria for immediate (extremely urgent or urgent) notification to CDC?

State reporting the notification.

County reporting the notification.

National jurisdiction reporting the notification to CDC.

Condition or event that constitutes the reason the notification is being sent

Date of birth in YYYYMMDD format

Subject's current sex

Field containing one or more codes that broadly refer to the subject's race(s).

County of residence of the subject

State of residence of the subject

ZIP Code of residence of the subject

Based on the self-identity of the subject as Hispanic or Latino

Country of Birth

Census tract where the address is located is a unique identifier associated with a small statistical subdivision of a county. Census tract data allows a user to find population and housing statistics about a specific part of an urban area. A single community may be composed of several census tracts.

Where does the person usually\* live (defined as their residence)

\*For the definition of 'usual residence' refer to CSTE position statement # 11-SI-04 titled "Revised Guidelines for Determining Residency for Disease Reporting" at <http://www.cste.org/ps2011/11-SI-04.pdf>.

Identifier for the physical site from which the notification is being submitted.

Status of the investigation

Date the investigator was assigned to this investigation.

Date the event or illness was first reported by the reporting source (physician or lab reported to the local/county/state health department).

Type of facility or provider associated with the source of information sent to Public Health.

ZIP Code of the reporting source for this case.

Earliest date reported to county public health system

Earliest date reported to state public health system

Was subject hospitalized because of this event?

Subject's admission date to the hospital for the condition covered by the investigation.

Subject's discharge date from the hospital for the condition covered by the investigation.

Subject's duration of stay at the hospital for the condition covered by the investigation.

Date of diagnosis of condition being reported to public health system

Date of the beginning of the illness. Reported date of the onset of symptoms of the condition being reported to the public health system

Time at which the disease or condition ends.

Length of time this subject had this disease or condition.

Unit of time used to describe the length of the illness or condition.

Did the subject die from this illness or complications of this illness?

If the subject died from this illness or complications associated with this illness, indicate the date of death

The date the case investigation was initiated.

Denotes whether the reported case was associated with an identified outbreak.

A state-assigned name for an identified outbreak.

Indication of where the disease/condition was likely acquired.

If the disease or condition was imported, indicates the country in which the disease was likely acquired.

If the disease or condition was imported, indicates the state in which the disease was likely acquired.

If the disease or condition was imported, indicates the city in which the disease was likely acquired.

If the disease or condition was imported, contains the county of origin of the disease or condition.

Code for the mechanism by which disease or condition was acquired by the subject of the investigation.

Status of the case/event as suspect, probable, confirmed, or not a case per CSTE/CDC/ surveillance case definitions.

MMWR Week for which case information is to be counted for MMWR publication.

MMWR Year (YYYY) for which case information is to be counted for MMWR publication.

States use this field to link NEDSS investigations back to their own state investigations.

Note: This may be any state-assigned ID number for the case; may be different than INV168, which is the system-assigned unique identified for the 'case' of disease being reported.

Date the case was first reported to the CDC

Earliest date the case was reported to the public health department whether at the local, county, or state public health level.

Indicates whether the subject was pregnant at the time of the event.

Name of the person who is reporting the case to the CDC

Phone Number of the person who is reporting the case to the CDC

Job title / description of the person reporting the case to the CDC

Affiliated Facility of the person reporting the case to the CDC

CDC uses this field to link current case notifications to case notifications submitted by a previous system (NETSS, STD-MIS, etc.)

Subject age at time of case investigation

Subject age units at time of case investigation

Indicates the country in which the disease was potentially acquired.

Indicates the state in which the disease was potentially acquired.

Business Rule: If Country of exposure was US, populate with US State. If Country of exposure was Mexico, populate with Mexican State. If country of exposure was Canada, populated with Canadian Province. For all other countries, leave null.

Indicates the city in which the disease was potentially acquired.

Business Rule: If country of exposure is US, populate with US city. For all other cities, can be populated but not required.

Note: Since value set only includes US cities, would allow states to populate the CWE 9th component with another city.

Indicates the county in which the disease was potentially acquired.

Business Rule: If country of exposure is US, populate with US county. Otherwise, leave null.

For cases meeting the binational criteria, select all the criteria which are met

Date of earliest healthcare encounter/visit /exam associated with this event/case report. May equate with date of exam or date of diagnosis.

If event = some stage of syphilis, does the patient have neurologic involvement based on current case definition?

Date treatment initiated for the condition that is the subject of this case report.

Documented or self-reported HIV status at the time of event.

Had sex with a male within past 12 months?

Had sex with a female within past 12 months?

Had sex with an anonymous partner within past 12 months?

Had sex with a person known to him/her to be an IDU within past 12 months?

Had sex while intoxicated and/or high on drugs within past 12 months?

Exchanged drugs/money for sex within past 12 months?

Had sex with a person who is known to her to be an MSM within past 12 months?

NOTE: For women only.

Engaged in injection drug use within past 12 months?

During the past 12 months, which of the following injection or non-injection drugs have been used?

Does the patient have a history of ever having had an STD prior to the condition reported in this case report?

Been incarcerated within past 12 months?

Did the patient use an online computer site to exchange messages by typing them onscreen to engage in conversation with other visitors to the site for the purpose of having sex?

Total number of sex partners that the case patient has had in the last 12 months.

Total partners equal the sum of all male, female, and transgender partners during the period.

If condition = any stage of syphilis, report anatomic site(s) of clinician-observed lesion(s) (e.g., chancre, rash, condyloma lata) at time of initial exam or specimen collection. Mark all that apply.

What type of non-treponemal serologic test for syphilis was performed on specimen collected to support case patient's diagnosis of syphilis?

If the test performed provides a quantifiable result, provide quantitative result (e.g. if RPR is positive, provide titer, e.g. 1:64)

Example: If titer is 1:64, enter 64; if titer is 1:1024, enter 1024.

Patient refused to answer questions regarding number of sex partners

Unknown number of sex partners in last 12 months

Date of collection of initial laboratory specimen used for diagnosis of health event reported in this case report. PREFERRED date for assignment of MMWR week. First date in hierarchy of date types associated with case report/event.

Anatomic site or specimen type from which positive lab specimen was collected.

Date result sent from Reporting Laboratory.

Was the HIV status of this case investigated through search of eHARS?

Stateno from eHARS registry for HIV+ cases.

Mode of exposure from eHARS for HIV+ cases.

Was this case selected by reporting jurisdiction for enhanced investigation?

How case patient first came to the attention of the health department for this condition

What type of treponemal serologic test for syphilis was performed on specimen collected to support case patient's diagnosis of syphilis?

represents # of cases reported in this 'record'; supports aggregate-(when >1) or case-specific (when=1) reporting.

date of disease in YYMMDD format. This date depends upon how case dates are assigned in the STD program. i.e., date could be the onset of symptoms date, diagnosis date, laboratory result date, date case first recognized and/or reported to STD program, or date case reported to CDC.

describes the type of date provided in Event date

What version of the NETSS record layout are you providing?

STD-Associated Lab Tests

STD-Associated Lab Results

Injection or non-injection drug use indicator

If the test performed provides a quantifiable result, provide quantitative result (e.g. if RPR is positive, provide titer, e.g. 1:64)  
Example: If titer is 1:64, enter 64; if titer is 1:1024, enter 1024.

Qualitative test result of STD123 Nontreponemal serologic syphilis test result (quantitative)

If the test performed provides a qualitative result, provide qualitative result, e.g. weakly reactive.

Neurological manifestations of disease

Infection of any eye structure with *T. pallidum*, as evidenced by manifestations including posterior uveitis, panuveitis, anterior uveitis, optic neuropathy, and retinal vasculitis.

Infection of the cochleovestibular system with *T. pallidum*, as evidenced by manifestations including sensorineural hearing loss, tinnitus, and vertigo.

Late clinical manifestations of syphilis (tertiary syphilis) may include inflammatory lesions of the cardiovascular system, skin, bone, or other tissue. Certain neurologic manifestations (e.g., general paresis and tabes dorsalis) are late clinical manifestations of syphilis.

Patient identified as transgender (i.e., an individual's personal sense of being male, female, or transgender).

Patient identified sexual orientation (i.e., an individual's physical and/or emotional attraction to another individual of the same gender, opposite gender, or both genders).

Date treatment associated with the condition was prescribed

Date treatment associated with the condition was administered

Name of the antibiotic administered

Dose of the antibiotic administered

Prescribed duration of antibiotic

Complications associated with the illness being reported

Indicator for associated complication

Dose of the treatment associated with the condition

Unit of measure for the treatment associated with the condition

Route of delivery of treatment

Frequency of treatment drug

Unit of measure for the frequency of treatment associated with the condition

Unit of measure for the duration of treatment associated with the condition

Route of delivery of drug(s) used

Sex assigned at birth

A person's identification of their emotional, romantic, sexual, or affectional attraction to another person

A person's internal sense of being a man, woman, both, or neither

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

PHVS\_NameType\_HL7\_2x

PHVS\_NotificationSectionHeader\_CDC

PHVS\_NotificationSectionHeader\_CDC

PHVS\_ResultStatus\_NND

PHVS\_NationalReportingJurisdiction\_NND

PHVS\_State\_FIPS\_5-2

PHVS\_County\_FIPS\_6-4

PHVS\_NationalReportingJurisdiction\_NND

PHVS\_NotifiableEvent\_Disease\_Condition\_CDC\_NNDSS

PHVS\_RaceCategory\_CDC

PHVS\_County\_FIPS\_6-4

PHVS\_State\_FIPS\_5-2

PHVS\_EthnicityGroup\_CDC\_Unk

PHVS\_CountryofBirth\_CDC

PHVS\_CountryofBirth\_CDC

PHVS\_CaseInvestigationStatus\_NND

PHVS\_ReportingSourceType\_NND

PHVS\_YesNoUnknown\_CDC

PHVS\_AgeUnit\_UCUM

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_DiseaseAcquiredJurisdiction\_NETSS

PHVS\_Country\_ISO\_3166-1

PHVS\_State\_FIPS\_5-2

PHVS\_City\_USGS\_GNIS

PHVS\_County\_FIPS\_6-4

PHVS\_CaseTransmissionMode\_NND

PHVS\_CaseClassStatus\_NND

PHVS\_YesNoUnknown\_CDC

PHVS\_AgeUnit\_UCUM\_NETSS

PHVS\_CountryofBirth\_CDC

PHVS\_State\_FIPS\_5-2

PHVS\_BinationalReportingCriteria\_CDC

New Value Set  
PHVS\_Neurological\_involvement\_CDC

New Value Set  
PHVS\_HIVStatus\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_DrugsUsed\_CDC

New Value Set  
PHVS\_PreviousSTDhistory\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_Clinician-observed lesions\_CDC

New Value Set  
PHVS\_nontreponemalserologictest\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

New Value Set  
PHVS\_SpecimenSource\_CDC

PHVS\_YesNoUnknown\_CDC

New Value Set  
PHVS\_TransCateg\_CDC  
PHVS\_YesNoUnknown\_CDC

New Value Set  
PHVS\_DetectionMethod\_CDC

New Value Set  
PHVS\_treponemalserologic\_CDC

##### Default=00001 for case-specific records where a single case is represented by data record.

YYMMDD Unknown=999999

1=Onset Date 2=Date of diagnosis 3=Date of laboratory result 4=Date of first report to community health system 5=State/MMWR report date 9=Unknown

i.e. Version 3 (January 2011) 03=Version 3  
STD-Associated RCMT Lab Tests (OBX-3)  
STD-Associated RCMT Lab Results (OBX-5)

New Value Set  
PHVS\_YNRD\_CDC

New Value Set  
PHVS\_QuantitativeSyphilisTestResult\_STD

New Value Set  
PHVS\_LabTestReactivity\_NND

New Value Set  
PHVS\_LabTestResultQualitative\_NND

|     |   |
|-----|---|
| TBD | O |
| TBD | O |
| TBD | O |
| TBD | O |
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| TBD | O |
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| TBD | O |
| TBD | O |
| TBD | O |

TBD (to align with USCDI standards)

TBD (to align with USCDI standards)

TBD (to align with USCDI standards)



CDC Priority  
(New)

1

1

1

Label/Short Name

AgClinic

AgClinicTestType

AgeMnth

AgeYr

AgSphl

AgSphlTestType

Biold

BloodyDiarr

Diarrhea

DtAdmit2

DtDisch2

DtEntered

DtRcvd

DtRptComp

DtSpec

DtUSDepart

DtUSReturn

EforsNum

Fever

HospTrans

HUS

Immigrate

Interview

LabName

LocalID

OtherCdcTest

OtherClinicTest

OtherClinicTestType

OtherSphlTest

OtherSphlTestType

OutbrkType

PatID

PcrCdc

PcrClinic

PcrClinicTestType

PcrSphl

PersonID  
ResultID  
RptComp  
SentCDC  
SLabsID  
SpecSite  
StecH7  
StecHAg  
StecNM  
StecO157  
StecOAg  
StecStx  
StLabRcvd

TravelDest  
TravelInt  
PulseNet Key  
Date of interview  
Respondent  
Other Respondent  
City of residence  
Month of birth  
Year of birth  
Hispanic or Latino  
Total days ill  
Still ill  
Diarrhea  
Diarrhea onset  
Bloody stool  
Still hospitalized  
HUS  
Food handler  
Daycare worker  
Foods at home  
Foods away from home  
Handled raw ground beef

Ground beef  
Ground beef at home  
Pink ground beef at home  
Ground beef at home purchase  
location  
Ground beef at home purchase date

Ground beef brand  
Ground beef bulk

Ground beef patties  
Ground beef other  
Ground beef unknown purchase  
form  
Home ground beef size  
Percent lean  
Fresh ground beef  
Frozen ground beef  
Unknown fresh/frozen ground beef

Ground beef away from home  
Gound beef away from home  
location  
Pink ground beef away  
Hamburger  
Meatball  
Meatloaf  
Taco  
Ground beef in a dish  
Other form of ground beef outside  
home

Specify other form of ground beef  
Steak  
Steak at home  
Pink steak at home  
Steak at home purchase location  
Steak at home purchase date  
Steak brand  
Steak consumed as steak  
Steak consumed as stew  
Steak consumed as roast  
Unknown steak type  
Steak consumed as other  
Specify how steak was consumed  
Steak away from home  
Steak away from home location  
Steak away from home dates  
Pink steak away  
Pink steak away as steak  
Pink steak away as stew  
Pink steak away as roast  
Pink steak away as other product

Specify how other pink steak was  
consumed  
Bison  
Bison at home

Pink bison at home  
Bison purchase location  
Bison purchase date  
Bison at home brand  
Bison away from home  
Bison away location  
Bison away date  
Pink bison away from home  
Wild game  
Dried meat  
Pepperoni  
Salami  
Sausage  
Other dried meat  
Type of other dried meat  
Jerky  
Raw milk  
Raw cheese  
Raw cheese type  
Raw cheese location  
Raw cheese date  
Raw ice cream  
Raw juice

Lettuce  
Lettuce at home  
Lettuce at home purchase location  
Lettuce at home purchase date  
Lettuce at home brand  
Loose lettuce at home  
Prepackaged lettuce at home

Unknown packaging of lettuce at home

Lettuce away from home

Lettuce away from home location  
Mesclun lettuce  
Mesclun lettuce at home  
Mesclun lettuce at home purchase location  
Mesclun lettuce at home purchase date  
Mesclun lettuce at home brand  
Loose mesclun lettuce at home  
Prepackaged mesclun lettuce at home

Unknown packaging of mesclun  
lettuce at home

Mesclun lettuce away from home

Mesclun lettuce away from home  
location

Iceberg lettuce

Iceberg lettuce at home

Iceberg lettuce at home purchase  
location

Iceberg lettuce at home purchase  
date

Iceberg lettuce at home brand

Loose iceberg lettuce at home

Prepackaged iceberg lettuce at home

Unknown packaging of iceberg  
lettuce at home

Iceberg lettuce away from home

Iceberg lettuce away from home  
location

Romaine lettuce

Romaine lettuce at home

Romaine lettuce at home purchase  
location

Romaine lettuce at home purchase  
date

Romaine lettuce at home brand

Loose romaine lettuce at home

Prepackaged romaine lettuce at  
home

Unknown packaging of romaine  
lettuce at home

Romaine lettuce away from home

Romaine lettuce away from home  
location

Red leaf lettuce

Red leaf lettuce at home

Red leaf lettuce at home purchase  
location

Red leaf lettuce at home purchase  
date

Red leaf lettuce at home brand

Loose red leaf lettuce at home

Prepackaged red leaf lettuce at home

Unknown packaging of red leaf lettuce at home

Red leaf lettuce away from home

Red leaf lettuce away from home location

Spinach

Spinach at home

Spinach at home purchase location

Spinach at home purchase date

Spinach at home brand

Loose spinach at home

Prepackaged spinach at home

Unknown packaging of spinach at home

Spinach away from home

Spinach away from home location

Other leafy greens

Other leafy greens at home

Other leafy greens at home purchase location

Other leafy greens at home purchase date

Other leafy greens at home brand

Loose other leafy greens at home

Prepackaged other leafy greens at home

Unknown packaging of other leafy greens at home

Other leafy greens away from home

Other leafy greens away from home location

Sprouts

Sprouts at home

Sprouts at home purchase locations

Sprouts at home purchase date

Sprouts at home brand

Sprouts away from home

Sprouts away from home location

Sprouts way from home type

Petting zoo

Farm with livestock

Farm and Feed store

Pet store

Fair

Pet treats

Animal droppings

Daycare

Any travel

Domestic travel

Domestic travel start date

Domestic travel end date

International travel

International travel start date

International travel end date

Group meals

Institution

Institution location

Source of drinking water

Site ID

Disease

State Lab ID

Collection Date

Last Updated

Confirmed

Specimen Source

Test Result

Probable – laboratory-diagnosed

Probable – epi-linked

TTP

Ill contact

Gourmet cheese

Specify other leafy greens

Sprouts location

Sprouts brand

Treated recreational water

Untreated recreational water

Treated recreational water location

Untreated recreational water  
location

Other related diagnosis

Specify other related diagnosis

Shopper card consent

Ground beef at home brand

Steak at home brand

Steak at home frozen

Steak at home fresh

Bison brand

Wild game brand

Dried meat brand

Other dried meat brand

Pork

Pork at home

Pork at home purchase location

Pork at home brand

Pork at home ground

Pork at home whole

Pork at home other form

Specify other form of pork at home

Pork away from home

Pork away from home location

Pork away from home dish

Raw milk location

Raw milk brand

Raw cheese

Raw cheese brand

Raw cheese aged

Gourmet cheese location

Gourmet cheese brand

Raw juice location

Raw juice brand

Other raw dairy product

Specify other raw dairy product

Other raw dairy product location

Other raw dairy product brand

Raw dough

Leafy greens

Leafy greens location

Leafy greens brand

Loose leafy greens

Prepackaged leafy greens

Cabbage

Cabbage location

Cabbage brand

Arugula  
Arugula location  
Arugula brand  
Kale  
Kale location  
Kale brand  
Premade salad  
Premade salad location  
Premade salad brand  
Other prepackaged leafy greens  
Other prepackaged leafy greens  
location  
Other prepackaged leafy greens  
brand  
Other leafy greens location  
Other leafy greens brand  
Herbs  
Specify herbs  
Herbs location  
Herbs brand  
Specify petting zoo  
Specify type of livestock  
Specify fair  
Pet  
Specify pet  
Specify institution  
Treated recreational water type  
Untreated recreational water type  
Occupation  
Food allergy  
Special diet  
Specify Different Exposure Window

Specify Different Travel Exposure  
Window

WGS ID Number  
Reason for travel related to current  
illness

## Description

For possible E. coli cases: What was the result of specimen testing for Shiga toxin using an antigen-based test (e.g.EIA or lateral flow) at a clinical laboratory?

Name of antigen-based test used at clinical laboratory

Age of case-patient in months if patient is <1yr

Age of case-patient in years

For possible E. coli cases: What was the result of specimen testing for Shiga toxin using an antigen-based test (e.g.EIA or lateral flow) at a state public health laboratory?

Name of antigen-based test used at state public health laboratory

Was the pathogen identified by culture?

Did the case-patient have bloody diarrhea (self reported) during this illness?

Did the case-patient have diarrhea (self-reported) during this illness?

Date of hospital admission for second hospitalization for this illness

Date of hospital discharge for second hospitalization for this illness

Date case was entered into site's database

Date case-patient's specimen was received in laboratory for initial testing

Date case report form was completed

Case-patient's specimen collection date

If case-patient traveled internationally, date of departure from the U.S.

If case-patient traveled internationally, date of return to the U.S.

CDC FDOSS outbreak ID number

Did the case-patient have fever (self-reported) during this illness?

If case-patient was hospitalized, was s/he transferred to another hospital?

Did case patient have a diagnosis of HUS?

Did case-patient immigrate to the U.S.? (within 7 days of illness onset)

Was the case-patient interviewed by public health (i.e. state or local health department) ?

Name of submitting laboratory

Case-patient's medical record number

What was the result of specimen testing for Shiga toxin using another test at the CDC?

What was the result of specimen testing for Shiga toxin using another test at a clinical laboratory

Name of other test used at a clinical laboratory

What was the result of specimen testing for Shiga toxin using another test at a state public health laboratory?

Name of other test used at a state public health laboratory

Type of outbreak that the case-patient was part of

Case-patient identification number

What was the result of specimen testing for Shiga toxin using PCR at CDC?

What was the result of specimen testing for Shiga toxin using PCR at a clinical laboratory?

Name of PCR assay used

What was the result of specimen testing for Shiga toxin using PCR at a state public health laboratory?

Unique identification number for person or patient  
Unique identifier for laboratory result  
Is all of the information for this case complete?  
Was specimen or isolate forwarded to CDC for testing or confirmation?  
State lab identification number  
Case patient's specimen collection source  
Was it H7 antigen positive?  
What was the H-antigen number?  
Was the isolate non-motile?  
Was it O157 positive?  
What was the O-antigen number?  
Was E. coli Shiga toxin-producing?  
Was the isolate sent to a state public health laboratory? (Answer 'Yes' if it was sent to any state lab, even if it was sent to a lab outside of the case's state of residence)

If case-patient traveled internationally, to where did they travel?  
Did the case patient travel internationally? (within 7 days of onset)  
Identification tag in PulseNet database  
Date questionnaire administered to case  
Individual who was interviewed  
If case, parent, or spouse not interviewed, then who was?  
City where patient resides  
Month when patient was born  
Year when patient was born  
Is the patient of Hispanic or Latino origin  
Length of patient's illness in days  
Is the patient still ill  
Patient experienced 3 or more loose stools in 24-hour period  
Date patient first experienced 3 or more loose stools  
Patient experienced blood in stool  
Is the patient still hospitalized  
Patient diagnosed by doctor with HUS or kidney failure  
Patient works as a food handler at dining establishment  
Patient works in a daycare facility  
List of locations where foods eaten at home were purchased  
List of locations where foods were eaten outside of the home  
Patient handled raw ground beef (even if not consumed) in 7 days prior to illness onset  
Patient consumed ground beef in 7 days prior to illness onset  
Patient consumed ground beef at home in 7 days prior to illness onset  
Patient consumed red or pink ground beef at home in 7 days prior to illness onset  
Location(s) where ground beef consumed at home in 7 days prior to illness onset was purchased  
Date(s) when ground beef consumed at home in 7 days prior to illness onset was purchased  
Brand(s) of ground beef eaten at home in 7 days prior to illness onset  
Ground beef eaten at home was purchased in bulk

Ground beef eaten at home was purchased in pre-formed patties  
Ground beef eaten at home was purchased in other form  
Patient unable to recall form in which ground beef eaten at home was purchased

Size in which ground beef consumed at home was purchased  
Percentage lean of ground beef eaten at home  
Ground beef eaten at home was purchased fresh  
Ground beef eaten at home was purchased frozen  
Patient unable to recall if ground beef consumed at home was purchased fresh or frozen  
Patient consumed ground beef away from home in 7 days prior to illness onset  
Location(s) where ground beef consumed away from home

Patient consumed red or pink ground beef away from home  
Ground beef eaten outside the home as hamburger  
Ground beef eaten outside the home as meatball  
Ground beef eaten outside the home as meatloaf  
Ground beef eaten outside the home in a taco  
Ground beef eaten in a dish (ex. casserole) outside the home  
Ground beef eaten outside the home in form other than hamburger, meatball, meatloaf, taco, or in a dish

Other type of ground beef eaten outside the home  
Patient consumed steak in 7 days prior to illness onset  
Patient consumed steak at home in 7 days prior to illness onset  
Steak consumed at home was pink or red  
Location(s) where steak consumed at home was purchased  
Date(s) when steak consumed at home was purchased  
Brand(s) of steak eaten at home  
Steak was consumed as steak  
Steak was consumed in a stew  
Steak was consumed as a roast  
Patient unable to recall how steak was consumed  
Steak was consumed in form other than steak, stew, roast  
If steak was consumed in other form, then specify  
Patient consumed steak away from home in 7 days prior to illness onset  
Location(s) where steak was consumed away from home  
Date(s) when steak was consumed away from home  
Patient consumed red or pink steak away from home  
Patient consumed red or pink steak away from home as steak  
Patient consumed red or pink steak away from home as stew  
Patient consumed red or pink steak away from home as a roast  
Patient consumed red or pink steak away from home in form other than steak, stew, or roast  
Specify if 'Other' red or pink steak was reported

Patient consumed bison in the 7 days prior to illness onset  
Patient consumed bison at home in the 7 days prior to illness onset

Patient consumed red or pink bison at home  
Location(s) where ground beef consumed at home was purchased  
Date(s) when bison consumed at home was purchased  
Brand of bison purchased for home consumption  
Patient consumed bison away from home in 7 days prior to illness onset  
Location(s) where bison was consumed outside the home  
Date(s) when bison was consumed outside the home  
Bison eaten outside the home was red or pink  
Patient consumed wild game in the 7 days before illness onset  
Patient consumed dried meat in the 7 days before illness onset  
Patient consumed dried meat that was pepperoni  
Patient consumed dried meat that was salami  
Patient consumed dried meat that was sausage  
Patient consumed dried meat that was not pepperoni, salami, or sausage  
Specify other type of dried meat consumed  
Patient consumed jerkey of any type in the 7 days before illness onset  
Patient consumed raw milk in the 7 days before illness onset  
Patient consumed cheese made with raw milk in the 7 days before illness onset  
Type of raw milk cheese consumed  
Location(s) where raw milk cheese was purchased  
Date(s) when raw milk cheese was purchased  
Patient consumed ice cream made with raw milk in the 7 days before illness onset  
Patient consumed raw or unpasteurized juice or cide in the 7 dayse before illness onset  
onset  
Patient consumed lettuce of any kind in the 7 days before illness onset  
Patient consumed lettuce of any kind at home in the 7 days before illness onset  
Location(s) where lettuce consumed at home was purchased  
Date(s) when lettuce consumed at home was purchased  
Brand(s) of lettuce purchased for home consumption  
Patient consumed loose lettuce of any kind in the 7 days before illness onset  
Patient consumed prepackaged lettuce of any kind in the 7 days before illness onset  
  
Patient unable to recall how lettuce consumed at home was packaged  
  
Patient consumed lettuce of any kind away from home in the 7 days before illness onset  
Location(s) where the lettuce was consumed away from home  
Patient consumed mesclun lettuce in the 7 days before illness onset  
Patient consumed mesclun lettuce at home in the 7 days before illness onset  
Location(s) where mesclun lettuce consumed at home was purchased  
  
Date(s) when mesclun lettuce consumed at home was purchased  
  
Brand(s) of mesclun lettuce consumed at home  
Patient consumed loose mesclun lettuce at home  
Patient consumed prepackaged mesclun lettuce at home

Patient unable to recall how mesclun lettuce consumed at home was purchased

Patient consumed mesclun lettuce away from home in the 7 days before illness onset

Location(s) where the mesclun lettuce was consumed away from home

Patient consumed iceberg lettuce in the 7 days before illness onset

Patient consumed iceberg lettuce at home in the 7 days before illness onset

Location(s) where iceberg lettuce consumed at home was purchased

Date(s) when iceberg lettuce consumed at home was purchased

Brand(s) of iceberg lettuce consumed at home

Patient consumed iceberg mesclun lettuce at home

Patient consumed prepackaged iceberg lettuce at home

Patient unable to recall how iceberg lettuce consumed at home was purchased

Patient consumed iceberg lettuce away from home in the 7 days before illness onset

Location(s) where the iceberg lettuce was consumed away from home

Patient consumed romaine lettuce in the 7 days before illness onset

Patient consumed romaine lettuce at home in the 7 days before illness onset

Location(s) where romaine lettuce consumed at home was purchased

Date(s) when romaine lettuce consumed at home was purchased

Brand(s) of romaine lettuce consumed at home

Patient consumed loose romaine lettuce at home

Patient consumed prepackaged romaine lettuce at home

Patient unable to recall how romaine lettuce consumed at home was purchased

Patient consumed romaine lettuce away from home in the 7 days before illness onset

Location(s) where the romaine lettuce was consumed away from home

Patient consumed red leaf lettuce in the 7 days before illness onset

Patient consumed red leaf lettuce at home in the 7 days before illness onset

Location(s) where red leaf lettuce consumed at home was purchased

Date(s) when red leaf lettuce consumed at home was purchased

Brand(s) of red leaf lettuce consumed at home

Patient consumed loose red leaf lettuce at home

Patient consumed prepackaged red leaf lettuce at home

Patient unable to recall how red leaf lettuce consumed at home was purchased

Patient consumed red leaf lettuce away from home in the 7 days before illness onset

Location(s) where the red leaf lettuce was consumed away from home

Patient consumed spinach in the 7 days before illness onset

Patient consumed spinach at home in the 7 days before illness onset

Location(s) where spinach consumed at home was purchased

Date(s) when spinach consumed at home was purchased

Brand(s) of spinach consumed at home

Patient consumed spinach at home

Patient consumed prepackaged spinach at home

Patient unable to recall how spinach consumed at home was purchased

Patient consumed spinach away from home in the 7 days before illness onset

Location(s) where the spinach was consumed away from home

Patient consumed other leafy greens in the 7 days before illness onset

Patient consumed other leafy greens at home in the 7 days before illness onset

Location(s) where other leafy greens consumed at home was purchased

Date(s) when other leafy greens consumed at home was purchased

Brand(s) of other leafy greens consumed at home

Patient consumed other leafy greens at home

Patient consumed prepackaged other leafy greens at home

Patient unable to recall how other leafy greens consumed at home was purchased

Patient consumed other leafy greens away from home in the 7 days before illness onset

Location(s) where the other leafy greens was consumed away from home

Patient consumed sprouts of any kind in the 7 days before illness onset

Patient consumed sprouts of any kind at home in the 7 days before illness onset

Location(s) where sprouts consumed at home were purchased

Date(s) when sprouts consumed at home were purchased

Brand(s) of sprouts consumed at home

Patient consumed sprouts of any kind away from home in the 7 days before illness onset

Location(s) where sprouts were consumed away from home

Type of sprouts consumed outside the home

Patient visited a petting zoo in the 7 days before illness onset

Patient visited, worked, or lived on a farm with livestock in the 7 days before illness onset

Patient visited an agricultural 'Farm and Feed' store in the 7 days before illness onset

Patient visited a pet store, swap meets, or other places where animals/birds are sold or shown in the 7 days before illness onset

Patient visited a county or state fair, 4-H event, or similar event with animals in the 7 days before illness onset

Patient had contact with pet treats or chews in the 7 days before illness onset

Patient had contact with dried animal droppings or pellets in the 7 days before illness onset

Patient attended or had contact with a daycare facility in the 7 days before illness onset

Patient spent all or some of the 7 days before illness onset outside of their state of residence

Postal code abbreviation of state(s) where patient traveled

Domestic travel start date

Domestic travel end date

Countries visited in the 7 days before illness onset

International travel start date

International travel end date

Patient attended a group meal in the 7 days before illness onset

Patient visited, lives, or works in an institutional home (jail, nursing home, etc.)

Location of institution where patient visits, lives, or works

Main source of drinking water for patient during the 7 days before illness onset

Site ID assigned by CDC.

Foodborne Disease.

Identification of Isolate

Date isolate taken from patient

Date of Last Modification

Is isolate confirmed

Source of isolate

Serotype/Species/Test Result

Probable case is laboratory-diagnosed

Probable case is epidemiologically linked

Patient had a diagnosis of TTP (Thrombotic thrombocytopenic purpura)

Patient had close contact with anyone with diarrhea or vomiting in the 7 days prior to illness onset

Patient consumed artisanal or gourmet cheese in the 7 days before illness onset

Specify other leafy greens

Purchase location of sprouts

Brand and variety of sprouts

Visit or swim in any treated recreational water facilities in 7 days prior to illness onset

Visit or swim in any untreated recreational water facilities in 7 days prior to illness onset

Location of treated recreational water facilities

Location of untreated recreational water facilities

Other related diagnosis

Specify other related diagnosis

Consent to retrieve purchases based on shopper card information

Brand and variety of ground beef consumed at home

Brand and variety of steak consumed at home

Steak consumed at home was purchased frozen

Steak consumed at home was purchased fresh

Brand and variety of bison

Brand and variety of wild game

Brand and variety of dried or fermented meat

Brand and variety of other dried or fermented meat

Patient consumed pork in 7 days prior to illness onset

Patient consumed pork at home in 7 days prior to illness onset

Purchase location of pork consumed at home

Brand and variety of pork consumed at home

Pork consumed at home was ground

Pork consumed at home was whole pig

Pork consumed at home was other form

Specify other type of pork consumed at home

Patient consumed pork away from home in 7 days prior to illness onset

Purchase location of pork consumed away from home

Dish in which pork was consumed away from home

Purchase location of raw milk

Brand and variety of raw milk

Purchase location of cheese made from raw milk

Brand and variety of cheese made from raw milk

Cheese made from raw milk was aged for 60 days

Purchase location of artisanal or gourmet cheese

Brand and variety of artisanal or gourmet cheese

Purchase location of unpasteurized juice or cider

Brand and variety of unpasteurized juice or cider

Patient consumed any other unpasteurized dairy product in 7 days prior to illness onset

Specify other unpasteurized dairy product

Purchase location of other unpasteurized dairy product

Brand and variety of other unpasteurized dairy product

Patient ate, tasted, or licked uncooked or unbaked dough or batter

Patient consumed fresh, uncooked leafy greens in 7 days prior to illness onset

Purchase location of fresh, uncooked leafy greens

Brand and variety of fresh, uncooked leafy greens

Patient consumed loose fresh, uncooked leafy greens

Patient consumed prepackaged fresh, uncooked leafy greens

Patient consumed cabbage in 7 days prior to illness onset

Purchase location of cabbage

Brand and variety of cabbage

Patient consumed arugula in 7 days prior to illness onset  
Purchase location of arugula  
Brand and variety of arugula  
Patient consumed kale in 7 days prior to illness onset  
Purchase location of kale  
Brand and variety of kale  
Patient consumed pre-made, single-serving salads in 7 days prior to illness onset  
Purchase location of pre-made, single-serving salads  
Brand and variety of pre-made, single-serving salads  
Patient consumed other pre-packaged leafy greens or salad kits  
Purchase location of other pre-packaged leafy greens or salad kits

Brand and variety of other pre-packaged leafy greens or salad kits

Purchase location of other leafy greens  
Brand and variety of other leafy greens  
Patient consumed fresh herbs in 7 days prior to illness onset  
Specify fresh herbs  
Purchase location of fresh herbs  
Brand and variety of fresh herbs  
Specify petting zoo  
Specify type of livestock  
Specify fair or event with animals  
Patient has a pet of their own  
Specify pet  
Specify institution  
Types of treated recreational water facilities  
Types of untreated recreational water facilities  
Patient's occupation  
Does the patient have a food allergy?  
Is the patient on a special diet?  
If the epidemiologic exposure window used by the jurisdiction is different from that stated in the exposure questions, specify the time interval in days here. Otherwise, leave blank.

If the travel exposure window used by the jurisdiction is different from that stated in the travel exposure questions, specify the time interval in days here. Otherwise, leave blank.

Whole Genome Sequencing (WGS) ID Number  
Reason for travel related to current illness

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

Self; Parent; Spouse; Other

12-Jan

Hispanic; Non-Hispanic; Unknown

Yes; No  
Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown  
Yes; No  
Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown

Yes; No

Yes; No

Yes; No

Yes; No

Number of pounds; Unknown

Percentage; Unknown

Yes; No

Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No

Yes; No

Yes; No

Yes; No

Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No

Yes; No

Yes; No

Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No

Yes; No

Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown  
Yes; No  
Yes; No  
Yes; No  
Yes; No

Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown

Yes; No  
Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown  
Yes; No; Maybe; Unknown

Yes; No  
Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No

Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No

Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No

Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No

Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No

Yes; No

Yes; No

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

Yes; No; Maybe; Unknown

City/municipal; Well; Bottled; Unknown

N/A

P

N/A

P

N/A  
PHVS\_TravelPurpose\_FDD



CDC Priority (New)



Label/Short Name

Clinically Compatible Illness

History of Tick Bite

Eschar

Immunosuppressive Condition

Adult respiratory distress syndrome

Disseminated Intravascular  
Coagulation

Meningitis

Encephalitis

Renal Failure

Other life threatening complication

Laboratory Name

Laboratory State

Acute Serology Collection Date

Acute IFA IgG Result

Acute IFA IgG Titer

Acute IFA IgM Result

Acute IFA IgM Titer

Acute Serology, Other Test

Acute Serology Result, Other Test

Acute Serology Numeric Result,  
Other Test

Convalescent Serology Collection  
Date

Convalescent IFA IgG Result

Convalescent IFA IgG Titer

Convalescent IFA IgM Result

Convalescent IFA IgM Titer

Convalescent Serology, Other Test

Convalescent Serology Result, Other  
Test

Convalescent Serology Numeric  
Result, Other Test

PCR

Morulae

Immunostain

Culture

Fourfold

Other Etiologic Agent

Physician Name

Physician Phone

Clinical Manifestation

Clinical Manifestation Indicator

Experienced Complication

Type of Complication

Patient Immunocompromised

Treatment Drug Indicator

Medication Administered

Date Treatment or Therapy Started

Treatment Duration

Occupation related to exposure

Travel

International Destination(s) of  
Recent Travel

Travel State

Travel County

Date of Arrival to Travel Destination

Date of Departure from Travel  
Destination

Tick Bite Location

Tick Bite Date

Blood Transfusion

Blood Transfusion Date

Transfusion Associated

Transfused Product

Organ Transplant

Transplant type

Transplant date

Transplant associated infection

Blood Donor

Blood Donation Date

Blood Donor Implicated During  
Investigation

Donated Product

Blood bank notified

Co-infection  
Co-infection type

## Description

Did this case have a clinically compatible illness as defined by the latest CSTE case definitions?

Was there a history of a tick bite within 14 days of onset?

Was there an eschar, or tache noire, present?

If the case reports an immunosuppressive condition, then indicate condition here

Did the case report adult respiratory distress syndrome during the course of this illness?

Did the case report disseminated intravascular coagulation during the course of this illness?

Did the case report meningitis during the course of this illness?

Did the case report encephalitis during the course of this illness?

Did the case report renal failure during the course of this illness?

If the case reported another life threatening complication during the course of this illness, then list it here

Indicate the name of the laboratory which supplied results supporting the current CSTE case definitions.

Indicate the state where the laboratory is located

If an acute serology was collected, then list the date of collection

If performed, was the acute IFA IgG positive

If performed, what was the reciprocal titer of the acute IFA IgG

If performed, was the acute IFA IgM positive

If performed, what was the reciprocal titer of the acute IFA IgM

If performed, what was the name of another acute serology test

If performed, was this other acute serology test positive

If performed, what was the numeric result of the other serology test

If an convalescent serology was collected, then list the date of collection

If performed, was the convalescent IFA IgG positive

If performed, what was the reciprocal titer of the convalescent IFA IgG

If performed, was the convalescent IFA IgM positive

If performed, what was the reciprocal titer of the convalescent IFA IgM

If performed, what was the name of another convalescent serology test

If performed, was this other convalescent serology test positive

If performed, what was the numeric result of the other serology test

If performed, was the polymerase chain reaction assay positive

If performed, were morulae visualized during microscopy

If performed, were antibodies detected using immunohistochemistry during microscopy

If performed, was the etiologic agent isolated from culture

If paired sera were collected, was there a fourfold change in titer between acute and convalescent

If etiologic agent was unusual, then indicate the species here (for example, *R. africae*)

Name of subject's clinician/provider of care, Provide the name in the following format: <last name>, <first name>

Phone number of subject's clinician/provider of care

Clinical manifestation of TBRD

For each clinical manifestation reported, indicate (YNU) whether the subject developed the specified manifestation as a result of the illness.

Did the subject experience any complications due to this episode?

If the subject experienced complications due to this episode, what was the complication?

At the time of diagnosis, was the subject immunocompromised?

Did the subject receive antimicrobial treatment for this infection?

What antibiotic did the patient receive for this episode?

Date the treatment was initiated

Number of days the patient actually took the antibiotic referenced

Is the subject's current occupation related to the exposure?

In the two weeks before symptom onset or diagnosis (use earlier date), did the subject travel out of their county, state, or country of residence?

International destination, countries traveled to

Domestic destination, state(s) traveled to

Intrastate destination, counties traveled to

If the subject traveled, when did they arrive to their travel destination?

If the subject traveled, when did they depart from their travel destination?

If subject noticed tick bite, where did the bite occur (geographic location)?

If subject noticed tick bite, when did the bite occur?

In the year before symptom onset or diagnosis (use earlier date), did the subject receive a blood transfusion?

Date(s) of blood transfusion(s)

Was the subject's infection transfusion associated?

If a transfused blood product was implicated in an investigation, specify which type(s) of product.

In the year before symptom onset or diagnosis (use earlier date), did the subject receive an organ transplant(s)?

If the subject received an organ transplant, what was the organ?

Date(s) of organ transplant(s)

Was the subject's infection transplant-related?

Did the subject donate blood in the 30 days prior to symptom onset?

Date(s) of blood donation(s)

Was the subject a blood donor identified during a transfusion investigation (i.e., had positive test results and was linked to an infected recipient)?

If a donated blood product was implicated in an investigation, specify which type(s) of product.

Was the blood bank/hospital/transplant service notified?

Was the subject diagnosed with a co-infection?  
Specify coinfection

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_State\_FIPS\_5-2

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

|                                 |   |
|---------------------------------|---|
| N/A                             | P |
| N/A                             | P |
| PHVS_ClinicalManifestation_TBRD | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_Complication_TBRD          | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_MedicationReceived_TBRD    | P |
|                                 | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_State_FIPS_5-2             | P |
| PHVS_County_FIPS_6-4            | P |
|                                 | P |
|                                 | P |
| PHVS_YesNoUnknown_CDC           | P |
|                                 | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_BloodProduct_CDC           | P |
| PHVS_YesNoUnknown_CDC           | P |
|                                 | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_YesNoUnknown_CDC           | P |
| PHVS_BloodProduct_CDC           | P |
| PHVS_YesNoUnknown_CDC           | O |

PHVS\_YesNoUnknown\_CDC

P  
P

Label/Short Name

Date of Illness Onset

Primary occupation

Military Service

Military Service Year

Tetanus Toxoid Vaccination

Year of last tetanus dose

Acute wound

Acute wound date

Acute wound anatomic site

Acute wound work related

Acute wound environment

Acute wound circumstances

Acute wound type

Wound Contaminated

Depth of Wound

Acute wound signs of infection

Denervated Tissue Present

Acute wound medical care

Acute wound tetanus toxoid  
administered

If Yes, tetanus toxoid administered,  
How Soon after Injury?

Wound Debrided

If Yes, Debrided How Soon after  
Injury?

TIG given before symptom onset

If Yes, TIG Given How Soon after  
Injury?

TIG given before symptom onset  
dosage

Tetanus Associated Condition

Diabetes

Insulin dependents

Parenteral Drug Abuse?

Tetanus type

TIG given after symptom onset

If Yes, How Soon after Injury?

TIG given after symptom onset  
dosage

Intensive Care Unit

Mechanical Ventilation Days

Final outcome

Mother's Age

Mother's DOB

Date mother first resided in the U.S.

Mother tetanus vacc number of  
known doses

Last time mother received tetanus  
vacc

Infant's birth place location

Birth attendees

## Description

Date of the beginning of the illness. Reported date of the onset of symptoms of the condition being reported to the public health system

Specifies patient's primary occupation.

History of Military (Active or Reserve)?

Year of Entry into Militart Service

Tetanus Toxoid (TT) History Prior to  
Tetanus Disease

(Exclude Doses Received Since Acute Injury)

Specifies the year of patients' last tetanus dose.

Did the patient have an acute wound or injury?

This field indicates the date an acute wound or injury occurred.

Specifies the anatomic site of acute wound or injury.

If there was an acute wound or injury, was it work related?

Specifies the environment where the acute wound or injury was work related.

Specifies the circumstances under which the acute wound or injury occurred.

Specifies the principle acute wound or injury type.

Wound Contaminated

Depth of Wound

Were there signs of infection at the time of care for the acute wound or injury?

Devitalized, Ischemic, or Denervated Tissue Present?

Did the patient obtain medical care for the acute wound or injury before tetanus symptom onset?

Was patient administered tetanus toxiod (Td, TT, DT, DTaP) for the acute wound or injury before tetanus symptom onset?

If Yes, How Soon after Injury?

Wound Debrided before Tetanus Onset

If Yes, Debrided How Soon after Injury?

Indicates whether tetanus immune globulin (TIG) prophylaxis was given as a part of the wound care before tetanus symptom onset.

If Yes, TIG Given How Soon after Injury?

Specifies the date the tetanus immune globulin (TIG) prophylaxis units given.

Tetanus Associated Conditions Prior to Onset(If no Acute Injury)

Indicates whether patient have diabetes.

Indicates whether the patient is insulin dependent.

Pranteral Drug Abuse?

Type of tetanus.

Indicates whether the tetanus immune globulin (TIG) therapy was given after symptom onset.

If Yes, How Soon after Injury?

Specifies the total therapeutic TIG dosage.

Was the patient in the Intensive Care Unit (ICU)?

Number of days the patient received mechanically ventilation.

Final outcome (e.g. Recovered, Died, Unknown)

Specifies mothers age.

Specifies mothers DOB.

Date mother first resided in the U.S.

Specifies number of known tetanus vaccination doses mother received prior to the infant's (case's) birth.

Specifies number of years or months since mother received last tetanus vaccination.

Specifies infant's (case) birth place location (e.g. Hospital, Home, Other, Unknown).

Specifies birth attendees (e.g. Physician, Nurse, Licensed midwife, Unlicensed midwife, Family, EMS technician(s)).

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

0 = Never  
1 = 1 dose  
2 = 2 doses  
3 = 3 doses  
4 = 4 + doses  
9 = Unknown

PHVS\_YesNoUnknown\_CDC

Body Region (Tetanus)

PHVS\_YesNoUnknown\_CDC

Injury Occurred Environment (VPD)

Injury Type (VPD)

PHVS\_YesNoUnknown\_CDC

1 = 1 cm or less  
2 = more than 1 cm  
9 = Unknown

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_AfterInjury\_Time

PHVS\_YesNoUnknown\_CDC

PHVS\_AfterInjury\_Time

PHVS\_YesNoUnknown\_CDC

PHVS\_AfterInjury\_Time

PHVS\_TET\_Associated\_Conditions

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

Tetanus Type (VPD)

PHVS\_YesNoUnknown\_CDC

PHVS\_AftterInjury\_Time

PHVS\_YesNoUnknown\_CDC

Treatment Outcome Tetanus (VPD)

PHVS\_VaccineDosesReceived\_Tetanus

PHVS\_BirthLocation\_VPD

PHVS\_BirthAttendees\_VPD

Label/Short Name

Eosinophilia

Eosin Absolute

Eosin Units

Fever

Temperature

Temperature Units

Trichinellosis Signs and Symptoms  
Code(s)

Trichinellosis Signs and Symptoms  
Other

Suspected Foods

Pork Type Code

Pork Type Other

Pork Consumed Date

Pork Larvae Found

Pork Source Obtained Code

Pork Source Other

Pork Prep Code

Pork Prep Other

Pork Cook Method Code

Pork Cook Method Other

Non-Pork Type Code

Non-Pork Type Other

Non-Pork Consumed Date

Non-Pork Larvae Found Code

Non-Pork Source Code

Non-Pork Source Other

Non-Pork Prep Code

Non-Pork Prep Other

Non-Pork Method Code

Non-Pork Method Other

Reporting Lab Name

Reporting Lab CLIA Number

Local record ID (case ID)

Filler Order Number

Ordered Test Name

Date of Specimen Collection

Specimen Site

Specimen Number  
Specimen Source

Specimen Details  
Date Sample Received at Lab  
Sample Analyzed date  
Lab Report Date  
Report Status  
Resulted Test Name  
Numeric Result  
Result Units  
Coded Result Value  
Organism Name

Lab Result Text Value  
Result Status  
Interpretation Flag

Reference Range From

Reference Range To

Test Method

Lab Result Comments

Date received in state public health  
lab

Lab Test Coded Comments  
Sent to CDC for Genotyping  
Genotyping Sent Date

Sent For Strain ID  
Strain Type  
Track Isolate  
Patient status at specimen collection

Isolate received in state public health  
lab

Reason isolate not received  
Reason isolate not received (Other)  
Date received in state public health  
lab

State public health lab isolate id  
number

Case confirmed at state public health lab

Travel History

International Destination(s) of Recent Travel

Travel State

Date of Arrival to Travel Destination

Date of Departure from Travel Destination

Epi-Linked

Where Meat Tested

Meat Comments

## Description

Did patient have Eosinophilia?

If "Yes," please specify absolute number or percentage:

Specify percent or numeric

Did patient have a fever?

If "Yes," please specify temperature:

Specify fahrenheit or celsius

Did patient have any of the following signs or symptoms of Trichinellosis?

If "Other," please specify other signs or symptoms of Trichinellosis:

What suspect foods did the patient eat?

Please specify type of pork:

If "Other," please specify other type of pork:

Date suspect food was consumed:

Was larvae found in suspect food?

Where was the suspect meat obtained?

If "Other," please specify where suspect meat was obtained:

How was suspect food prepared or further processed after purchase?

If "Other," please specify other type of processing:

What was the method of cooking the suspect food?

If "Other," please specify other type of cooking method:

Please specify type of non-pork:

If "Other," please specify other type of non-pork:

Date suspect food was consumed:

Was larvae found in suspect food?

Where was the suspect meat obtained?

If "Other," please specify where suspect meat was obtained:

How was suspect food prepared or further processed after purchase?

If "Other," please specify other type of processing:

What was the method of cooking the suspect food?

If "Other," please specify other type of cooking method:

Name of Laboratory that reported test result.

CLIA (Clinical Laboratory Improvement Act) identifier for the laboratory that performed the test.

Sending system-assigned local ID of the case investigation with which the subject is associated. This field has been added to provide the mapping to the case/investigation to which this lab result is associated. This field should appear exactly as it appears in OBR-3 of the Case Notification.

A laboratory generated number that identifies the test/order instance.

Ordered Test Name is the lab test ordered by the physician. It will always be included in an ELR, but there are many instances in which the user entering manual reports will not have access to this information.

The date the specimen was collected.

This indicates the physical location, of the subject, where the specimen originated. Examples include: Right Internal Jugular, Left Arm, Buttock, Right Eye, etc.

A laboratory generated number that identifies the specimen related to this test.  
The medium from which the specimen originated. Examples include whole blood, saliva, urine, etc.

Specimen details if specimen information entered as text.

Date Sample Received at Lab (accession date).

The date and time the sample was analyzed by the laboratory.

Date result sent from Reporting Laboratory.

The status of the lab report.

The lab test that was run on the specimen.

Results expressed as numeric value/quantitative result.

The unit of measure for numeric result value.

Coded qualitative result value (e.g., Positive, Negative).

The organism name as a test result. This element is used when the result was reported as an organism.

Textual result value, used if result is neither numeric nor coded.

The Result Status is the degree of completion of the lab test.

The interpretation flag identifies a result that is not typical as well as how it's not typical. Examples: Susceptible, Resistant, Normal, Above upper panic limits, below absolute low.

The reference range from value allows the user to enter the value on one end of a expected range of results for the test. This is used mostly for quantitative results.

The reference range to value allows the user to enter the value on the other end of a valid range of results for the test. This is used mostly for quantitative results.

The technique or method used to perform the test and obtain the test results.  
Examples: Serum Neutralization, Titration, dipstick, test strip, anaerobic culture.

Comments having to do specifically with the lab result test. These are the comments from the NTE segment if the result was originally an Electronic Laboratory Report.

Date the isolate was received in state public health laboratory.

Explanation for missing result (e.g., clotting, quantity not sufficient, etc.)

Indicate whether the specimens were sent to CDC for genotyping.

If the specimen was sent to the CDC for genotyping, date on which the specimens were sent.

Indicate whether the specimen was sent for strain identification.

If the specimen was sent for strain identification, indicate the strain.

Track Isolate functionality indicator

Patient status at specimen collection

Isolate received in state public health lab

Reason isolate not received

Reason isolate not received (Other)

Date received in state public health lab

State public health lab isolate id number

Case confirmed at state public health lab

In the 8 weeks before onset of illness, did the subject travel out of their state or country of residence?

International destination or countries the case-patient traveled to in the 8 weeks before onset of illness

Domestic destination or state(s) the case-patient traveled to in the 8 weeks before onset of illness

Date of arrival to travel destination

Date of departure from travel destination

Is this case epi-linked to another confirmed or probable case?

Where was the suspected meat tested?

Use this field, if needed, to communicate anything unusual about the suspect meat, which is not already covered with the other data elements (e.g., additional details about where eaten, if consumed while traveling outside of the U.S., where wild game was hunted, etc.).

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

PHVS\_YesNoUnknown\_CDC

Eosin Units\_FDD

PHVS\_YesNoUnknown\_CDC

PHVS\_TemperatureUnit\_UCUM

PHVS\_TrichinellosisSignsSymptoms\_FDD

PHVS\_SuspectedFoodConsumed\_FDD

PHVS\_PorkType\_FDD

PHVS\_PresentAbsentUnkNotExamined\_CDC

PHVS\_MeatPurchaseInfo\_FDD

PHVS\_FoodProcessingMethod\_FDD

PHVS\_FoodCookingMethod\_FDD

PHVS\_NonPorkType\_FDD

PHVS\_PresentAbsentUnkNotExamined\_CDC

PHVS\_MeatPurchaseInfo\_FDD

PHVS\_FoodProcessingMethod\_FDD

PHVS\_FoodCookingMethod\_FDD

PHVS\_BodySite\_CDC

PHVS\_Specimen\_CDC

PHVS\_ResultStatus\_HL7\_2x

PHVS\_LabTestName\_CDC

PHVS\_UnitsOfMeasure\_CDC

PHVS\_LabTestResultQualitative\_CDC

PHVS\_Microorganism\_CDC

PHVS\_ObservationResultStatus\_HL7\_2x

PHVS\_AbnormalFlag\_HL7\_2x

PHVS\_LabTestMethods\_CDC

PHVS\_MissingLabResult\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_YesNoUnknown\_CDC

PHVS\_MicrobiologicalStrain\_CDC

PHVS\_TrueFalse\_CDC

PHVS\_PatientLocationStatusAtSpecimenCollection

PHVS\_YesNoUnknown\_CDC

PHVS\_IsolateNotReceivedReason\_NND

PHVS\_YesNoUnknown\_CDC

CDC Priority

| Label/Short Name                      | Description                                                                                                                       | Value Set Code.<br>Search in PHIN<br>VADS using the<br>following link<br>( <a href="https://phinvads.cdc.gov/vads/SearchHome.action">https://phinvads.cdc.gov/vads/SearchHome.action</a> ) |   |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|
| TB State Case Number                  | State case number for the case specific to TB investigations (4 digit report year + 2 letter state + 9 digit alphanumeric number) | N/A                                                                                                                                                                                        | P |
| City or County Case Number            | City or county case number assigned to this case                                                                                  | N/A                                                                                                                                                                                        | P |
| Birth Sex                             | What was the patient's sex at birth?                                                                                              | PHVS_Sex_MFU                                                                                                                                                                               | P |
| Previously Counted Case               | Has this case already been counted by another reporting area?                                                                     | PHVS_CaseCountStatus_TB                                                                                                                                                                    | P |
| Previously Reported State Case Number | If case previously counted, provide the state case number from the other reporting area.                                          | N/A                                                                                                                                                                                        | P |
| Country of Verified Case              | If the case was previously reported by another country, specify the country.                                                      | PHVS_BirthCountry_CDC                                                                                                                                                                      | P |
| Patient Address City                  | Patient address city                                                                                                              | N/A                                                                                                                                                                                        | P |
| Inside City Limits                    | Is the patient's residence within city limits?                                                                                    | PHVS_YesNoUnknown_CDC                                                                                                                                                                      | P |

|                                        |                                                                                                                                                                                                                                                 |                       |   |
|----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---|
| Census Tract of Case-Patient Residence | Census tract where the address is located is a unique identifier associated with a small statistical subdivision of a county. Census tract data allows a user to find population and housing statistics about a specific part of an urban area. | N/A                   | P |
| Detailed Race                          | Provide the detailed race information for the patient.                                                                                                                                                                                          | PHVS_Race_CDC         | P |
| Date Arrived in US                     | If country of birth is NOT United States, regardless of citizenship, indicate the date when the patient first arrived in the US.                                                                                                                | N/A                   | P |
| US Born                                | Was the patient eligible for US citizenship at birth?                                                                                                                                                                                           | PHVS_YesNoUnknown_CDC | P |
| Primary Guardian(s) Country of Birth   | Indicates the birth country of the primary guardian(s) of patient (pediatric [<15 years old] cases only)                                                                                                                                        | PHVS_BirthCountry_CDC | P |
| Remain in US After Report              | If not US reporting area, did patient remain in the United States for >= 90 days after report date?                                                                                                                                             | PHVS_YesNoUnknown_CDC | P |

|                               |                                                               |                                    |   |
|-------------------------------|---------------------------------------------------------------|------------------------------------|---|
| Initial Reason for Evaluation | What was the initial reason the patient was evaluated for TB? | PHVS_PrimaryReasonForEvaluation_TB | P |
|-------------------------------|---------------------------------------------------------------|------------------------------------|---|

|           |                                                                                                                                                                                                                                                     |                     |   |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---|
| Test Type | Epidemiologic interpretation of the type of test(s) performed for this case. Please provide a response for each of the main test types (culture, smear, pathology/cytology, NAA, TST, IGRA, HIV, diabetes) If test was not done please indicate so. | PHVS_LabTestType_TB | P |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---|

|             |                                                                                                                                                              |                               |   |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---|
| Test Result | Epidemiologic interpretation of the results of the test(s) performed for this case - This is a qualitative test result. (e.g., positive, detected, negative) | PHVS_LabTestInterpretation_TB | P |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---|

|                         |                                                                                             |     |   |
|-------------------------|---------------------------------------------------------------------------------------------|-----|---|
| Date/Time of Lab Result | Date result sent from reporting laboratory. Time of result is an optional addition to date. | N/A | P |
|-------------------------|---------------------------------------------------------------------------------------------|-----|---|

|                      |                                                              |                                    |   |
|----------------------|--------------------------------------------------------------|------------------------------------|---|
| Specimen Source Site | This indicates the anatomical source of the specimen tested. | PHVS_MicroscopicExamCultureSite_TB | P |
|----------------------|--------------------------------------------------------------|------------------------------------|---|

|                                      |                                                                                                                                                                                            |                                    |   |
|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|---|
| Specimen Collection Date/Time        | Date of collection of laboratory specimen used for diagnosis of health event reported in this case report. Time of collection is an optional addition to date.                             | N/A                                | P |
| Test Result Quantitative             | Quantitative test result value                                                                                                                                                             | N/A                                | P |
| Result Units                         | Units of measure for the Quantitative Test Result Value                                                                                                                                    | PHVS_UnitofMeasure_TB              | P |
| Type of Chest Study                  | Indicate the type of chest study performed. Please provide a response for each of the main test types (plain chest radiograph, chest CT Scan) and if test was not done please indicate so. | PHVS_TypeofRadiologyStudy_CDC      | P |
| Result of Chest Study                | Result of chest diagnostic testing                                                                                                                                                         | PHVS_ResultofRadiologyStudy_TB     | P |
| Evidence of Cavity                   | Did test show evidence of cavity?                                                                                                                                                          | PHVS_YesNoUnknown_CDC              | P |
| Evidence of Miliary TB               | Did test show evidence of miliary TB?                                                                                                                                                      | PHVS_YesNoUnknown_CDC              | P |
| Date of Chest Study                  | Date of the chest diagnostic study                                                                                                                                                         | N/A                                | P |
| Patient Epidemiological Risk Factors | Exposed risk factors for the patient - Please provide a response for all risk factors in the value set with an associated indicator                                                        | PHVS_EpidemiologicalRiskFactors_TB | P |

|                                                |                                                                                         |                       |   |
|------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------|---|
| Patient Epidemiological Risk Factors Indicator | Provide a response for each value in the patient epidemiological risk factors value set | PHVS_YesNoUnknown_CDC | P |
|------------------------------------------------|-----------------------------------------------------------------------------------------|-----------------------|---|

|                               |                                                                                                                          |                                   |   |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---|
| Type of Correctional Facility | If patient was a Resident of Correctional Facility at Diagnostic Evaluation, indicate the type of correctional facility. | PHVS_CorrectionalFacilityType_NND | P |
|-------------------------------|--------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---|

|                                 |                                                                                                                              |                                   |   |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---|
| Type of Long-Term Care Facility | If patient was a Resident of Long Term Care Facility at Diagnostic Evaluation, indicate the type of long term care facility. | PHVS_LongTermCareFacilityType_NND | P |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---|

|                |                                                       |                        |   |
|----------------|-------------------------------------------------------|------------------------|---|
| Smoking Status | What is the patient's current tobacco smoking status? | PHVS_SmokingStatus_CDC | P |
|----------------|-------------------------------------------------------|------------------------|---|

|                                                    |                                                                                                                                                                                                            |                       |   |
|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---|
| Patient lived outside of US for more than 2 months | Residence or Travel in countries other than the United States, Canada, Australia, New Zealand, or countries in northern or western Europe for >60 consecutive days at any point in the patient's lifetime. | PHVS_YesNoUnknown_CDC | P |
|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|---|

|                                         |                                                                                            |                       |   |
|-----------------------------------------|--------------------------------------------------------------------------------------------|-----------------------|---|
| Identified During Contact Investigation | Was the patient identified during the contact investigation around the likely source case? | PHVS_YesNoUnknown_CDC | P |
|-----------------------------------------|--------------------------------------------------------------------------------------------|-----------------------|---|

|                                         |                                                                                                                                                                                                      |                                     |   |
|-----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|---|
| Evaluation During Contact Investigation | If patient was identified during contact investigation, was the patient evaluated for TB during the contact investigation?                                                                           | PHVS_YesNoUnknown_CDC               | P |
| Linked Case Number                      | State case numbers for epidemiologically linked cases                                                                                                                                                | N/A                                 | P |
| Date Treatment or Therapy Started       | Date the initial treatment regimen was started                                                                                                                                                       | N/A                                 | P |
| Treatment Administration Type           | Choose all treatment administration types that apply to the case, such as DOT, eDOT, or SAT.                                                                                                         | PHVS_TreatmentAdministrationType_TB | P |
| Date Treatment or Therapy Stopped       | Date treatment stopped                                                                                                                                                                               | N/A                                 | P |
| Case Verification Category              | Indicates case verification criteria result based on factors such as culture results, smear results, major and additional sites of the disease, x-ray results, TST, IDR, reason therapy was stopped. | PHVS_CaseVerification_TB            | P |
| Status at Diagnosis of TB               | Was the patient alive or dead at the time of diagnostic evaluation?                                                                                                                                  | PHVS_GeneralConditionStatus_TB      | P |
| Site of Disease                         | What was the site of the patient's TB disease?                                                                                                                                                       | PHVS_AdditionalDiseaseSite_TB       | P |

|                                            |                                                                                                                   |                                  |   |
|--------------------------------------------|-------------------------------------------------------------------------------------------------------------------|----------------------------------|---|
| Contact Investigation                      | Was a contact investigation conducted around this case?                                                           | PHVS_YesNoUnknown_CDC            | P |
| Diagnosis Type                             | Previous TB or LTBI Diagnosis - Provide only 1 response for LTBI, multiple responses for TB are allowed           | PHVS_DiagnosisType_TB            | P |
| History of Previous Illness                | Did the subject have a history of TB or LTBI?                                                                     | PHVS_YesNoUnknown_CDC            | P |
| Date of Previous Illness                   | Date of previous diagnosis                                                                                        | N/A                              | P |
| Previous State Case Number                 | Previous TB or LTBI State Case Number                                                                             | N/A                              | P |
| Completed Treatment for Previous Diagnosis | Completed Treatment for Previous Diagnosis                                                                        | PHVS_YesNoUnknown_CDC            | P |
| Initially Treated with RIPE                | Was the patient initially treated with the recommended four-drug therapy (RIPE)?                                  | PHVS_YesNoUnknown_CDC            | P |
| Reason Not Treated with RIPE               | If not initially treated with RIPE, why not?                                                                      | PHVS_ReasonNotTreatedwithRIPE_TB | P |
| Reason Therapy Stopped                     | Indicate the primary reason that therapy was stopped or never started; specify this data when the case is closed. | PHVS_ReasonTherapyStopped_TB     | P |
| Reason Therapy Extended                    | Select the reason the therapy extended beyond 12 months.                                                          | PHVS_TherapyExtendedReason_TB    | P |
| Final Disease Outcome                      | Final TB disease case outcome                                                                                     | PHVS_FinalTreatmentOutcome_TB    | P |

|                      |                                                                                                                                            |                     |   |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---|
| Initial Drug Regimen | Initial drug regimen for the patient:<br>Please provide a response for each of the values in the value set using the associated indicator. | PHVS_Medications_TB | P |
|----------------------|--------------------------------------------------------------------------------------------------------------------------------------------|---------------------|---|

|                                |                                                          |                       |   |
|--------------------------------|----------------------------------------------------------|-----------------------|---|
| Initial Drug Regimen Indicator | Indicator response for the initial drug regimen question | PHVS_YesNoUnknown_CDC | P |
|--------------------------------|----------------------------------------------------------|-----------------------|---|

|                                  |                                          |                       |   |
|----------------------------------|------------------------------------------|-----------------------|---|
| Isolate Submitted for Genotyping | Was an isolate submitted for genotyping? | PHVS_YesNoUnknown_CDC | P |
|----------------------------------|------------------------------------------|-----------------------|---|

|                                 |                                                                                                                |     |   |
|---------------------------------|----------------------------------------------------------------------------------------------------------------|-----|---|
| Accession Number for Genotyping | If an isolate was submitted for genotyping to a CDC laboratory only, list the accession number for genotyping. | N/A | P |
|---------------------------------|----------------------------------------------------------------------------------------------------------------|-----|---|

|                                          |                                                               |                       |   |
|------------------------------------------|---------------------------------------------------------------|-----------------------|---|
| Phenotypic Drug Susceptibility Completed | Was phenotypic/growth-based drug susceptibility testing done? | PHVS_YesNoUnknown_CDC | P |
|------------------------------------------|---------------------------------------------------------------|-----------------------|---|

|                                         |                                                           |                       |   |
|-----------------------------------------|-----------------------------------------------------------|-----------------------|---|
| Molecular Drug Susceptibility Completed | Was genotypic/molecular drug susceptibility testing done? | PHVS_YesNoUnknown_CDC | P |
|-----------------------------------------|-----------------------------------------------------------|-----------------------|---|

|                                        |                                                                                                                                                                                                                                                      |                                 |   |
|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---|
| Antimicrobial Susceptibility Test Type | Antimicrobial Susceptibility Test Type of TB drugs. For the initial susceptibility testing please send a response for each values in the value set. Changes in susceptibility should be reported for each individual drug when change is identified. | PHVS_Susceptibility TestType_TB | P |
|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---|

|                                                       |                                                       |     |   |
|-------------------------------------------------------|-------------------------------------------------------|-----|---|
| Antimicrobial Susceptibility Specimen Collection Date | Antimicrobial Susceptibility Specimen Collection Date | N/A | P |
|-------------------------------------------------------|-------------------------------------------------------|-----|---|

|                                                   |                                                   |     |   |
|---------------------------------------------------|---------------------------------------------------|-----|---|
| Antimicrobial Susceptibility Result Reported Date | Antimicrobial susceptibility result reported date | N/A | P |
|---------------------------------------------------|---------------------------------------------------|-----|---|

|                                            |                                                                                |                                    |   |
|--------------------------------------------|--------------------------------------------------------------------------------|------------------------------------|---|
| Antimicrobial Susceptibility Specimen Type | Antimicrobial Susceptibility Specimen Type (e.g. Exudate, Blood, Serum, Urine) | PHVS_MicroscopicExamCultureSite_TB | P |
|--------------------------------------------|--------------------------------------------------------------------------------|------------------------------------|---|

|                                                  |                                                                                                          |                                               |   |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------|---|
| Antimicrobial Susceptibility Test Interpretation | Antimicrobial Susceptibility Test Interpretation (e.g. Susceptible, Resistant, Intermediate, Not tested) | PHVS_Susceptibility TestResultQuantitative_TB | P |
|--------------------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------|---|

|                                          |                                                                             |                                   |   |
|------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------|---|
| Antimicrobial Susceptibility Test Method | Antimicrobial Susceptibility Test Method (e.g. E-Test, MIC, Disk Diffusion) | PHVS_Susceptibility TestMethod_TB | P |
|------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------|---|

|                 |                                                                                                                                                                                                                                                                                                                                                                                                                                             |                  |   |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---|
| Gene Identifier | Gene identifier - Please report the full test results for the samples that have unique features, such as specimen type (sputum or another anatomic site), test type (sequencing or non-sequencing) or mutation (detected or not detected). There is no need to report test results that differ only by date or laboratory and where all other aspects are identical in regards to specimen type, test type, and/or the results of mutation. | PHVS_GeneName_TB | P |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|---|

|                                                   |                                                   |     |   |
|---------------------------------------------------|---------------------------------------------------|-----|---|
| Molecular Susceptibility Specimen Collection Date | Molecular Susceptibility Specimen Collection Date | N/A | P |
|---------------------------------------------------|---------------------------------------------------|-----|---|

|                                        |                                        |     |   |
|----------------------------------------|----------------------------------------|-----|---|
| Molecular Susceptibility Date Reported | Molecular Susceptibility Date Reported | N/A | P |
|----------------------------------------|----------------------------------------|-----|---|

|                                        |                                        |                                    |   |
|----------------------------------------|----------------------------------------|------------------------------------|---|
| Molecular Susceptibility Specimen Type | Molecular Susceptibility Specimen Type | PHVS_MicroscopicExamCultureSite_TB | P |
|----------------------------------------|----------------------------------------|------------------------------------|---|

|                                      |                                      |                              |   |
|--------------------------------------|--------------------------------------|------------------------------|---|
| Molecular Susceptibility Test Result | Molecular Susceptibility Test Result | PHVS_MolecularTestResults_TB | P |
|--------------------------------------|--------------------------------------|------------------------------|---|

|                                              |                                              |     |   |
|----------------------------------------------|----------------------------------------------|-----|---|
| Molecular Susceptibility Nucleic Acid Change | Molecular Susceptibility Nucleic Acid Change | N/A | P |
|----------------------------------------------|----------------------------------------------|-----|---|

|                                                      |                                                                                                                         |                                                    |   |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---|
| Molecular Susceptibility Amino Acid Change           | Molecular Susceptibility Amino Acid Change                                                                              | N/A                                                | P |
| Molecular Susceptibility Indel                       | Molecular Susceptibility Indel                                                                                          | PHVS_MolecularIndel_TB                             | P |
| Molecular Susceptibility Test Method                 | Molecular Susceptibility Test Method                                                                                    | PHVS_MolecularTestMethods_TB                       | P |
| Culture Conversion Documented                        | Did the patient's sputum become culture negative?                                                                       | PHVS_YesNoUnknown_CDC                              | P |
| Date of First Consistently Negative Culture          | Date the first consistently negative sputum culture was collected.                                                      | N/A                                                | P |
| Reason for Not Documenting Sputum Culture Conversion | Indicate the one reason for not documenting the sputum culture conversion.                                              | PHVS_SputumCultureConversionNotDocumentedReason_TB | P |
| Patient Move During TB Therapy                       | Did the patient move during therapy?                                                                                    | PHVS_YesNoUnknown_CDC                              | P |
| Moved to Where                                       | If the patient moved to a different reporting area during TB therapy, select all that apply to where the patient moved. | PHVS_MovedWhereDuringTherapy_TB                    | P |
| Out of State Move                                    | If moved out of state, then specify the new state jurisdiction.                                                         | PHVS_State_FIPS_5-2                                | P |
| Out of Country Move                                  | If moved out of country, then specify the new country jurisdiction.                                                     | PHVS_Country_ISO_3166-1                            | P |

|                                      |                                                                                                                                                                                                                                                             |                               |   |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---|
| Transnational Referral               | If moved out of the US, indicate whether a transnational referral was made.                                                                                                                                                                                 | PHVS_YesNoUnknown_CDC         | P |
| History of Treatment                 | History of treatment before current episode with second-line TB drugs for the treatment of TB disease (not LTBI)                                                                                                                                            | PHVS_YesNoUnknown_CDC         | P |
| Date MDR Treatment Started           | Date MDR TB therapy started for current episode                                                                                                                                                                                                             | N/A                           | P |
| Drug Used to Treat MDR TB            | Drugs ever used for MDR TB treatment, from MDR start date: Please provide a response for each medication in the value set with an associated indicator. Medications should be recorded as part of the regimen beginning with the MDR TB therapy start date. | PHVS_Medications_TB           | P |
| Length of Time Drug Was Administered | Indicate length of time drug was taken or if it was not taken                                                                                                                                                                                               | PHVS_LengthofTimeDrugTaken_TB | P |
| Date Injectable Medication Stopped   | Date injectable medication stopped. If no injectable drugs were used leave blank.                                                                                                                                                                           | N/A                           | P |
| Surgery to Treat MDR TB              | Surgery to Treat MDR TB                                                                                                                                                                                                                                     | PHVS_YesNoUnknown_CDC         | P |

|                                     |                                                                                                                                                                                                                                                                                                                                                 |                               |   |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---|
| Surgery to Treat MDR TB Date        | Surgery to Treat MDR TB Date                                                                                                                                                                                                                                                                                                                    | N/A                           | P |
| Adverse Event Description           | Did patient experience any of the following side effects during treatment that resulted in a permanent discontinuation of medication or at the end of treatment were there any of the following side effects related to MDR-TB treatment present? Please provide a response for all side effects in the value set with an associated indicator. | PHVS_SideEffectofTreatment_TB | P |
| Adverse Event Indicator             | Side Effects of Treatment Indicator                                                                                                                                                                                                                                                                                                             | PHVS_YesNoUnknown_CDC         | P |
| Adverse Event Manifestation Time    | Did the side effect manifest during treatment or at the end of treatment?                                                                                                                                                                                                                                                                       | PHVS_SideEffectTimeToOnset_TB | P |
| Usual Occupation and Industry       | Usual occupation and industry                                                                                                                                                                                                                                                                                                                   | TBD                           | P |
| Meets Binational Reporting Criteria | Does case meet binational reporting criteria?                                                                                                                                                                                                                                                                                                   | PHVS_YesNoUnknown_CDC         | P |
| Patient Treated as MDR Case         | Was the Patient Treated as an MDR TB Case (Regardless of DST Results?                                                                                                                                                                                                                                                                           | PHVS_YesNoUnknown_CDC         | P |

| Label/Short Name                 | Description                                                                        |
|----------------------------------|------------------------------------------------------------------------------------|
| Immunocompromised                | If patient has any immunocompromising conditions, specify                          |
| Date first medical               | Date that the patient was first seen by medical person.                            |
| Fever/sweats/chills              | Did the patient's illness include the symptom of fever/sweats/chills?              |
| Confusion/delirium               | Did the patient's illness include the symptom of confusion/delirium?               |
| Vomiting/diarrhea/abdominal pain | Did the patient's illness include the symptom of vomiting/diarrhea/abdominal pain? |
| Sore throat                      | Did the patient's illness include the symptom of sore throat?                      |
| Cough                            | Did the patient's illness include the symptom of cough?                            |
| Chest Pain                       | Did the patient's illness include the symptom of chest pain?                       |
| Shortness of breath              | Did the patient's illness include the symptom of shortness of breath?              |
| Other_symptoms                   | Did the patient's illness include other symptoms of not listed?                    |
| Other_symptoms_specify           | Which other symptoms did the patient's illness include?                            |
| Lymphadenopathy                  | Did the patient have lymphadenopathy?                                              |
| Describe lymphadenopathy         | If lymphadenopathy present, provide location and description.                      |
| Skin lesions                     | Did the patient have skin lesion?                                                  |
| Describe skin lesions            | If skin lesion present, provide location and description.                          |
| Conjunctivitis                   | Did the patient have conjunctivitis?                                               |
| Pharyngitis/tonsilitis           | Did the patient have pharyngitis/tonsilitis?                                       |
| Chest X-ray                      | Results of chest x-ray                                                             |
| Antibiotic                       | Did patient receive an effective antibiotic for illness?                           |
| Antibiotic start date            | Date each antibiotic started                                                       |
| Illness outcome                  | Outcome of illness                                                                 |
| Primary clinical syndrome        | Classification of primary clinical manifestation of infection                      |
| <i>F. tularensis</i> cultured    | Was <i>F. tularensis</i> cultured?                                                 |
| Specimen source                  | Source of culture                                                                  |
| Date specimen collected          | Date specimen was collected                                                        |
| <i>F. tularensis</i> detected    | Was <i>F. tularensis</i> detected by other tests?                                  |
| Test performed                   | Test used to detect <i>F. tularensis</i>                                           |

|                                                     |                                                                                                                                          |
|-----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| Specimen source                                     | Specimen source in which <i>F. tularensis</i> was detected                                                                               |
| Date specimen collected                             | Date of specimen collection                                                                                                              |
| <i>F. tularensis</i> subspecies                     | Subspecies of <i>F. tularensis</i> detected                                                                                              |
| Serology                                            | Serology results                                                                                                                         |
| First Serum titer                                   | Titer results                                                                                                                            |
| Second Serum titer                                  | Titer results                                                                                                                            |
| Date first serum drawn                              | Date first serum drawn                                                                                                                   |
| Date second serum drawn                             | Date second serum drawn                                                                                                                  |
| Epi-linked to other cases                           | Was this illness epi-linked to any other tularemia cases?                                                                                |
| Epi-link specify                                    | Describe epi-linked case                                                                                                                 |
| Travel associated                                   | Was this illness associated with travel?                                                                                                 |
| Travel specify                                      | Describe travel                                                                                                                          |
| Animal contact                                      | Did patient have any animal contact in the 2 weeks preceding illness?                                                                    |
| Domestic animal                                     | Indicate if domestic animal contact occurred and specify domestic animals that patient had contact with in the 2 weeks preceding illness |
| Type of animal contact                              | Was animal domestic or wild                                                                                                              |
| Wild animal                                         | Indicate if wild animal contact occurred and specify wild animals that patient had contact with in the 2 weeks preceding illness         |
| Nature of contact                                   | Nature of animal contact                                                                                                                 |
| Tick or deerfly bite                                | Did patient have tick or deerfly bite in the two weeks preceding illness?                                                                |
| Contact with or ingestion of untreated water        | Did patient have contact with or ingestion of untreated water in the two weeks preceding illness?                                        |
| Environmental aerosol generating activities         | Did patient participate in any environmental aerosol generating activities in the two weeks preceding illness                            |
| Specify environmental aerosol generating activities | Specify environmental aerosol generating activities                                                                                      |
| Other exposure                                      | Specify any other exposures in the two weeks preceding illness                                                                           |
| Comments                                            | Additional comments                                                                                                                      |

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

|                       | CDC Priority |
|-----------------------|--------------|
| N/A                   | P            |
| N/A                   | P            |
| PHVS_YesNoUnknown_CDC | P            |
| PHVS_YesNoUnknown_CDC | P            |
| PHVS_YesNoUnknown_CDC | P            |
| PHVS_YesNoUnknown_CDC | P            |
| PHVS_YesNoUnknown_CDC | P            |
| PHVS_YesNoUnknown_CDC | P            |
| PHVS_YesNoUnknown_CDC | P            |
| PHVS_YesNoUnknown_CDC | P            |
| PHVS_YesNoUnknown_CDC | P            |
| N/A                   | P            |
| PHVS_YesNoUnknown_CDC | P            |
| N/A                   | P            |
| PHVS_YesNoUnknown_CDC | P            |
| N/A                   | P            |
| PHVS_YesNoUnknown_CDC | P            |
| PHVS_YesNoUnknown_CDC | P            |
| TBD                   | P            |
| TBD                   | P            |
| N/A                   | P            |
| TBD                   | P            |
| TBD                   | P            |
| PHVS_YesNoUnknown_CDC | P            |
| N/A                   | P            |
| N/A                   | P            |
| PHVS_YesNoUnknown_CDC | P            |
| N/A                   | P            |

|     |   |
|-----|---|
| N/A | P |
| N/A | P |
| TBD | P |
| TBD | P |
| N/A | P |
| N/A | P |
| N/A | P |
| N/A | P |

|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | P |
| N/A                   | P |
| PHVS_YesNoUnknown_CDC | P |
| N/A                   | P |

|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | P |
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|     |   |
|-----|---|
| N/A | P |
| TBD | P |

|     |   |
|-----|---|
| N/A | P |
| TBD | P |
| TBD | P |

|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | P |
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|                       |   |
|-----------------------|---|
| PHVS_YesNoUnknown_CDC | P |
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|     |   |
|-----|---|
| N/A | P |
|-----|---|

|     |   |
|-----|---|
| N/A | P |
| N/A | P |

| Label/Short Name                                                                                               | Description                                                                                                                                                                                                                                                  | Value Set Code. Search in PHN VADS using the following link ( <a href="https://phnmeds.cdc.gov/vads/SearchForm.action">https://phnmeds.cdc.gov/vads/SearchForm.action</a> ) |
|----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Number of lesions in total                                                                                     | Choose the numeric range within which a count of the patient's lesions falls. Note that PHVS_NumberOfLesions_VZ "Unknown" is not the FLZ Floor of Unknown value is sent.                                                                                     | PHVS_NumberOfLesions_VZ                                                                                                                                                     |
| Number of lesions if less than 50                                                                              | Number of lesions if less than 50                                                                                                                                                                                                                            |                                                                                                                                                                             |
| Did the patient receive Varicella-containing vaccine                                                           | Indicate whether the patient received varicella-containing vaccine; a value of Yes or No enables other fields in this section, allowing for answers to their questions.                                                                                      | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Reason why patient did not receive Varicella-containing vaccine                                                | If the value is Did the patient receive varicella-containing vaccine? is No, choose the reason why the patient did not receive the vaccine; if none of the specific choices in the list apply, choose Other.                                                 | PHVS_VaccineNotGivenReasons_CDC                                                                                                                                             |
| Other reason why patient did not receive varicella-containing vaccine                                          | If the value specified in Reason why patient did not receive varicella-containing vaccine is Other, indicate the reason (a reason other than those provided in the list).                                                                                    |                                                                                                                                                                             |
| Number of doses received on or after the first birthday                                                        | If the value is Did the patient receive varicella-containing vaccine? is Yes, indicate the number of doses received on or after the patient's first birthday.                                                                                                |                                                                                                                                                                             |
| Reason patient is <= 6 years old and received one dose on or after 6th birthday but never received second dose | Reason patient is <= 6 years old and received one dose on or after 6th birthday but never received second dose. Choose from the list the reason the patient never received the second dose; if none of the specific choices in the list apply, choose Other. | PHVS_VaccineNotGivenReasons_CDC                                                                                                                                             |
| Other reason patient did not receive second dose                                                               | If the value specified in Reason patient is <= 6 years old and received one dose on or after 6th birthday but never received second dose is Other, indicate the reason (a reason other than those provided in the list).                                     |                                                                                                                                                                             |
| Rash Onset Date                                                                                                | Date on which the physical manifestations of the illness—the rash—appeared                                                                                                                                                                                   |                                                                                                                                                                             |
| Rash Location                                                                                                  | The distribution of the rash on the body                                                                                                                                                                                                                     | PHVS_RashDistribution_VZ                                                                                                                                                    |
| Dermatome                                                                                                      | If a value of First is specified in the Rash Location field, enter the nerve where the rash occurred (limb or thoracic, with a number)                                                                                                                       | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Location First Noted                                                                                           | If a value of Generalized is specified for the Rash Location field, choose location where rash was first noted (if any); if none of the specific choices in the list apply, choose Other.                                                                    | PHVS_RashLocationFirstNoted_VZ                                                                                                                                              |
| Other Generalized rash location                                                                                | If a value of Other is specified in the Location First Noted, enter the location (i.e., the location where the rash was first noted is other than one of the values provided in the Location First Noted list)                                               |                                                                                                                                                                             |
| Macules Present                                                                                                | If the value specified in Total Number of Lesions is < 50, indicate whether macules were present.                                                                                                                                                            | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Number of Macules                                                                                              | If the value specified in Macules Present is Yes, indicate how many macules were present.                                                                                                                                                                    |                                                                                                                                                                             |
| Papules Present                                                                                                | If the value specified in Total Number of Lesions is < 50, indicate whether papules were present.                                                                                                                                                            | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Number of Papules                                                                                              | If the value specified in Papules Present is Yes, indicate how many papules were present.                                                                                                                                                                    |                                                                                                                                                                             |
| Vesicles Present                                                                                               | If the value specified in Total Number of Lesions is < 50, indicate whether vesicles were present.                                                                                                                                                           | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Number of Vesicles                                                                                             | If the value specified in Vesicles Present is Yes, indicate how many vesicles were present.                                                                                                                                                                  |                                                                                                                                                                             |
| Mostly macular/papular                                                                                         | Indicate whether the lesions were mostly macular/papular.                                                                                                                                                                                                    | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Mostly vesicular                                                                                               | Indicate whether the lesions were mostly vesicular.                                                                                                                                                                                                          | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Hemorrhagic                                                                                                    | Indicate whether the rash was hemorrhagic.                                                                                                                                                                                                                   | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Itchy                                                                                                          | Indicate whether the patient complained of itchiness.                                                                                                                                                                                                        | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Scabs                                                                                                          | Indicate whether there were scabs.                                                                                                                                                                                                                           | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Crust/Waves                                                                                                    | Indicate whether the lesions appeared in crups or waves.                                                                                                                                                                                                     | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Did rash crust                                                                                                 | Indicate whether the rash crusted.                                                                                                                                                                                                                           | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Number of Days until lesions crusted over                                                                      | If the value specified in Did the rash crust? is Yes, enter the number of days that the rash was present.                                                                                                                                                    |                                                                                                                                                                             |
| Number of Days rash lasted                                                                                     | If the value specified in Did the rash crust? is No, enter the number of days that the rash was present.                                                                                                                                                     |                                                                                                                                                                             |
| Fever                                                                                                          | Indicate whether the patient had a fever during the course of the illness.                                                                                                                                                                                   | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Fever Onset Date                                                                                               | If the value specified in Did patient have fever? is Yes, indicate the date when the fever began.                                                                                                                                                            |                                                                                                                                                                             |
| Highest measured temperature                                                                                   | If the value specified in Did patient have fever? is Yes, indicate the highest temperature that was measured.                                                                                                                                                |                                                                                                                                                                             |
| Temperature Units                                                                                              | Temperature Units (Fahrenheit or Celsius).                                                                                                                                                                                                                   | PHVS_TemperatureUnit_UCUM                                                                                                                                                   |
| Fever Duration in Days                                                                                         | If the value specified in Did patient have fever? is Yes, indicate the number of days for which the patient had a fever.                                                                                                                                     |                                                                                                                                                                             |
| Is patient immunocompromised due to medical condition or treatment                                             | Indicate whether the patient was immunocompromised (anergic).                                                                                                                                                                                                | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Medical Condition or Treatment                                                                                 | If Yes, indicate the medical condition or treatment associated with the patient being immunocompromised                                                                                                                                                      |                                                                                                                                                                             |
| Did patient visit a healthcare provider during this illness                                                    | Indicate whether the patient visited a healthcare provider during the course of this illness.                                                                                                                                                                | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Did patient develop any complications that were diagnosed by a healthcare provider?                            | If the value specified in Did patient visit a healthcare provider during this illness? is Yes, indicate whether the patient developed complications (as described).                                                                                          | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Skin/soft tissue infection                                                                                     | If the value specified in Did patient develop any complications that were diagnosed by a healthcare provider? is Yes, indicate whether there was skin or soft tissue infection.                                                                              | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Cerebellar/ ataxia                                                                                             | If the value specified in Did patient develop any complications that were diagnosed by a healthcare provider? is Yes, indicate whether there was cerebellar/ataxia.                                                                                          | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Encephalitis                                                                                                   | If the value specified in Did patient develop any complications that were diagnosed by a healthcare provider? is Yes, indicate whether there was encephalitis.                                                                                               | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Dehydration                                                                                                    | If the value specified in Did patient develop any complications that were diagnosed by a healthcare provider? is Yes, indicate whether the patient was diagnosed as being dehydrated.                                                                        | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Hemorrhagic condition                                                                                          | If the value specified in Did patient develop any complications that were diagnosed by a healthcare provider? is Yes, indicate whether there was hemorrhagic condition.                                                                                      | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Pneumonia                                                                                                      | If the value specified in Did patient develop any complications that were diagnosed by a healthcare provider? is Yes, indicate whether pneumonia was a complication.                                                                                         | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| How was pneumonia diagnosed                                                                                    | If the value in Pneumonia? is Yes, indicate how the pneumonia was diagnosed.                                                                                                                                                                                 | PHVS_DiagnosedPneumonia_VZ                                                                                                                                                  |
| Other complications                                                                                            | If the value specified in Did patient develop any complications that were diagnosed by a healthcare provider? is Yes, indicate whether there were other complications not identified.                                                                        | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Other complication details                                                                                     | If the value specified in Other Complications? is Yes, list the other complication(s).                                                                                                                                                                       |                                                                                                                                                                             |
| Antiviral treatment                                                                                            | Indicate whether the patient was treated with acyclovir, famvir, or any licensed antiviral.                                                                                                                                                                  | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Name of medication                                                                                             | If the value specified in Antiviral? is Yes, list the name of the medication.                                                                                                                                                                                | PHVS_MedicationsReceived_VZ                                                                                                                                                 |
| Name of Medication if 'Other'                                                                                  | If the value specified in 'Other', indicate name of medication                                                                                                                                                                                               |                                                                                                                                                                             |
| Start Date of Medication                                                                                       | Start date of medication.                                                                                                                                                                                                                                    |                                                                                                                                                                             |
| Stop Date of medication                                                                                        | Stop date of medication.                                                                                                                                                                                                                                     |                                                                                                                                                                             |
| Autopsy performed                                                                                              | If a value of Yes is specified in Did the patient die from this illness or complications associated with this illness?, indicate whether an autopsy was performed for the death.                                                                             | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Cause of death                                                                                                 | If a value of Yes is specified in Did the patient die from this illness or complications associated with this illness?, indicate the official cause of death.                                                                                                |                                                                                                                                                                             |
| Diagnosed with Varicella before                                                                                | Indicate whether the patient has a prior diagnosis of varicella.                                                                                                                                                                                             | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Age at diagnosis                                                                                               | Age at diagnosis                                                                                                                                                                                                                                             |                                                                                                                                                                             |
| Age at diagnosis units                                                                                         | Age at diagnosis units                                                                                                                                                                                                                                       | PHVS_AgeUnit_UCUM                                                                                                                                                           |
| Previous Case Diagnosed by                                                                                     | Indicate who diagnosed the illness; if none of the choices apply choose Other.                                                                                                                                                                               | PHVS_Diagnosed_By_VZ                                                                                                                                                        |
| Previous Case Diagnosed by Other                                                                               | If the value specified in Previous Case Diagnosed by is Other, indicate who diagnosed the case                                                                                                                                                               |                                                                                                                                                                             |
| Is this case epi-linked to another confirmed or probable case                                                  | Indicate whether this case is epi-linked to another case (confirmed or probable).                                                                                                                                                                            | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Type of case this case is epi-linked to                                                                        | If the value specified in Is this case epi-linked to another confirmed or probable case? is Yes, indicate the kind of case with which the current case is epi-linked.                                                                                        | PHVS_EpiLinkedCaseType_VZ                                                                                                                                                   |
| Transmission setting (setting of exposure)                                                                     | Location where the patient was exposed to the illness; if none of the specific choices in PHVS_TransmissionSetting_VAD the list apply, choose Other.                                                                                                         | PHVS_TransmissionSetting_VAD                                                                                                                                                |
| Other transmission setting                                                                                     | If the value specified in Transmission Setting? is Other, describe the other transmission setting.                                                                                                                                                           |                                                                                                                                                                             |
| Is this case a healthcare worker                                                                               | Indicate whether the patient who is the subject of the current case is a healthcare worker.                                                                                                                                                                  | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Number of weeks gestation                                                                                      | If the patient was pregnant during the illness, indicate the number of weeks of gestation at the onset of the illness.                                                                                                                                       |                                                                                                                                                                             |
| Trimester                                                                                                      | If the patient was pregnant during the illness, indicate the trimester at the onset of the PHVS_PregnancyTrimester_CDC illness.                                                                                                                              | PHVS_PregnancyTrimester_CDC                                                                                                                                                 |
| Was laboratory testing done for varicella?                                                                     | Was laboratory testing done for varicella?                                                                                                                                                                                                                   | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Direct fluorescent antibody (DFA)?                                                                             | Was direct fluorescent antibody (DFA) testing performed?                                                                                                                                                                                                     | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Date of DFA                                                                                                    | Date of DFA                                                                                                                                                                                                                                                  |                                                                                                                                                                             |
| DFA Result                                                                                                     | DFA Result                                                                                                                                                                                                                                                   | PHVS_LabTestInterpretation_CDC                                                                                                                                              |
| PCR specimen?                                                                                                  | PCR specimen?                                                                                                                                                                                                                                                | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Date of PCR specimen                                                                                           | Date of PCR specimen                                                                                                                                                                                                                                         |                                                                                                                                                                             |
| Source of PCR specimen                                                                                         | Source of PCR specimen                                                                                                                                                                                                                                       | PHVS_PCRSpecimenSource_VZ                                                                                                                                                   |
| Specify other PCR source                                                                                       | Specify other PCR source                                                                                                                                                                                                                                     |                                                                                                                                                                             |
| PCR Result                                                                                                     | PCR Result                                                                                                                                                                                                                                                   | PHVS_LabTestInterpretation_CDC                                                                                                                                              |
| Specify other PCR result                                                                                       | Specify other PCR result                                                                                                                                                                                                                                     |                                                                                                                                                                             |
| Culture performed?                                                                                             | Culture performed?                                                                                                                                                                                                                                           | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Date of Culture Specimen                                                                                       | Date of Culture Specimen                                                                                                                                                                                                                                     |                                                                                                                                                                             |
| Culture Result                                                                                                 | Culture Result                                                                                                                                                                                                                                               | PHVS_LabTestInterpretation_CDC                                                                                                                                              |
| Was other laboratory testing done?                                                                             | Was other laboratory testing done?                                                                                                                                                                                                                           | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Specify Other Test                                                                                             | Specify Other Test                                                                                                                                                                                                                                           | PHVS_LabTestMethod_VZ                                                                                                                                                       |
| Date of Other test                                                                                             | Date of Other test                                                                                                                                                                                                                                           |                                                                                                                                                                             |
| Other Lab Test Result                                                                                          | Other Lab Test Result                                                                                                                                                                                                                                        | PHVS_LabTestInterpretation_CDC                                                                                                                                              |
| Other Test Result Value                                                                                        | Other Test Result Value                                                                                                                                                                                                                                      |                                                                                                                                                                             |
| Serology performed?                                                                                            | Serology performed?                                                                                                                                                                                                                                          | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| IgM performed?                                                                                                 | IgM performed?                                                                                                                                                                                                                                               | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Type of IgM Test                                                                                               | Type of IgM Test                                                                                                                                                                                                                                             | PHVS_IgMTestType_VZ                                                                                                                                                         |
| Specify Other IgM Test                                                                                         | Specify Other IgM Test                                                                                                                                                                                                                                       |                                                                                                                                                                             |
| Date IgM Specimen Taken                                                                                        | Date IgM Specimen Taken                                                                                                                                                                                                                                      |                                                                                                                                                                             |
| IgM Test Result                                                                                                | IgM Test Result                                                                                                                                                                                                                                              | PHVS_LabTestInterpretation_CDC                                                                                                                                              |
| IgM Test Result Value                                                                                          | IgM Test Result Value                                                                                                                                                                                                                                        |                                                                                                                                                                             |
| IgG performed?                                                                                                 | IgG performed?                                                                                                                                                                                                                                               | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Type of IgG Test                                                                                               | Type of IgG Test                                                                                                                                                                                                                                             | PHVS_IgGTestType_VZ                                                                                                                                                         |
| If 'Whole Cell ELISA,' specify manufacturer                                                                    | If 'Whole Cell ELISA,' specify manufacturer                                                                                                                                                                                                                  | PHVS_WholeCellELISAManufacturer_VZ                                                                                                                                          |
| If 'IgG ELISA' specify manufacturer                                                                            | If 'IgG ELISA' specify manufacturer                                                                                                                                                                                                                          | PHVS_IgGELISAManufacturer_VZ                                                                                                                                                |
| Specify Other IgG Test                                                                                         | Specify Other IgG Test                                                                                                                                                                                                                                       |                                                                                                                                                                             |
| Date of IgG - Assay                                                                                            | Date of IgG - Assay                                                                                                                                                                                                                                          |                                                                                                                                                                             |
| IgG - Assay Result                                                                                             | IgG - Assay Result                                                                                                                                                                                                                                           | PHVS_LabTestInterpretation_CDC                                                                                                                                              |
| IgG - Assay Test Result Value                                                                                  | IgG - Assay Test Result Value                                                                                                                                                                                                                                |                                                                                                                                                                             |
| Date of IgG - Convalescent                                                                                     | Date of IgG - Convalescent                                                                                                                                                                                                                                   |                                                                                                                                                                             |
| IgG - Convalescent Result                                                                                      | IgG - Convalescent Result                                                                                                                                                                                                                                    | PHVS_LabTestInterpretation_CDC                                                                                                                                              |
| IgG - Convalescent Test Result Value                                                                           | IgG - Convalescent Test Result Value                                                                                                                                                                                                                         |                                                                                                                                                                             |
| Were the specimens sent to the CDC for genotyping (molecular typing)?                                          | Were the specimens sent to the CDC for genotyping (molecular typing)?                                                                                                                                                                                        | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Date sent for genotyping                                                                                       | Date sent for genotyping                                                                                                                                                                                                                                     |                                                                                                                                                                             |
| Was specimen sent for strain (wild- or vaccine type) identification?                                           | Was specimen sent for strain (wild- or vaccine type) identification?                                                                                                                                                                                         | PHVS_YesNoUnknown_CDC                                                                                                                                                       |
| Strain Type                                                                                                    | Strain Type                                                                                                                                                                                                                                                  | PHVS_StrainType_VZ                                                                                                                                                          |
| Vaccine Administered                                                                                           | The type of vaccine administered.                                                                                                                                                                                                                            | PHVS_VaccineAdministeredVZ_CDC_NP                                                                                                                                           |
| Vaccine Manufacturer                                                                                           | Manufacturer of the vaccine.                                                                                                                                                                                                                                 | PHVS_ManufacturerOfVaccineVZ_CDC_NP                                                                                                                                         |
| Vaccine Lot Number                                                                                             | The vaccine lot number of the vaccine administered.                                                                                                                                                                                                          |                                                                                                                                                                             |
| Vaccine Administered Date                                                                                      | The date that the vaccine was administered.                                                                                                                                                                                                                  |                                                                                                                                                                             |
| Case Investigation Status Code                                                                                 | Case Investigation Status Code, from NBS MM                                                                                                                                                                                                                  |                                                                                                                                                                             |
| Vaccinated per ACIP recommendations                                                                            | Was subject vaccinated as recommended by ACIP?                                                                                                                                                                                                               |                                                                                                                                                                             |
| Reason not vaccinated per ACIP recommendations                                                                 | Reason subject not vaccinated as recommended by ACIP                                                                                                                                                                                                         |                                                                                                                                                                             |
| Reason not vaccinated per ACIP, Other                                                                          | If other, specify reason not vaccinated per ACIP                                                                                                                                                                                                             |                                                                                                                                                                             |
| Treatment duration                                                                                             | Number of days antiviral taken                                                                                                                                                                                                                               |                                                                                                                                                                             |
| Specimen Description                                                                                           | Text description of the specimen                                                                                                                                                                                                                             |                                                                                                                                                                             |
| Test Type, other                                                                                               | If other, specify lab test                                                                                                                                                                                                                                   |                                                                                                                                                                             |
| Specimen sent to CDC                                                                                           | Was a specimen sent to CDC for testing?                                                                                                                                                                                                                      |                                                                                                                                                                             |
| Type of testing at CDC                                                                                         | What type of testing was done at CDC for this subject?                                                                                                                                                                                                       |                                                                                                                                                                             |
| Type of testing at CDC, other                                                                                  | If other, specify testing done at CDC                                                                                                                                                                                                                        |                                                                                                                                                                             |
| Date specimen sent to CDC                                                                                      | Date specimen sent to CDC                                                                                                                                                                                                                                    |                                                                                                                                                                             |
| Patient Address City                                                                                           | Patient address city, from NBS MM                                                                                                                                                                                                                            |                                                                                                                                                                             |
| Vaccine Administered Product Type, Other                                                                       | If other, specify type of vaccine administered                                                                                                                                                                                                               |                                                                                                                                                                             |
| Vaccine Product Manufacturer, Other                                                                            | If other, specify vaccine manufacturer                                                                                                                                                                                                                       |                                                                                                                                                                             |
| Date of last dose prior to illness onset                                                                       | Date of last disease-containing vaccination dose prior to illness onset                                                                                                                                                                                      |                                                                                                                                                                             |
| Vaccination doses prior to onset                                                                               | Number of disease-containing vaccination doses prior to illness onset                                                                                                                                                                                        |                                                                                                                                                                             |
| Vaccination Record ID                                                                                          | Vaccination Record ID, from NBS MM                                                                                                                                                                                                                           |                                                                                                                                                                             |
| Vaccine Expiration Date                                                                                        | Vaccine expiration date                                                                                                                                                                                                                                      |                                                                                                                                                                             |
| NDC Brand Name/Bar Code Information                                                                            | NDC from the vaccine's bar code. With the NDC code, vaccine brand name and manufacturer can be obtained.                                                                                                                                                     |                                                                                                                                                                             |
| Vaccine dose number                                                                                            | Indicates the dose number in a series_#0000_.                                                                                                                                                                                                                |                                                                                                                                                                             |
| Vaccine Event Information source                                                                               | Indicates whether the vaccine was administered by the provider organization recording the immunization or obtained from a historical record                                                                                                                  |                                                                                                                                                                             |
| Immunization Schedule used                                                                                     | Identifies the schedule used for immunization evaluation and forecast.                                                                                                                                                                                       |                                                                                                                                                                             |
| Exemption/refusal reason                                                                                       | Indicates the reason the patient is either exempt from the immunization or refuses the immunization                                                                                                                                                          |                                                                                                                                                                             |
| Laboratory Confirmed                                                                                           | Was the case laboratory confirmed?                                                                                                                                                                                                                           |                                                                                                                                                                             |
| Performing Laboratory Type                                                                                     | Performing laboratory type                                                                                                                                                                                                                                   |                                                                                                                                                                             |
| Performing Laboratory Type, Other                                                                              | If other, specify performing laboratory type                                                                                                                                                                                                                 |                                                                                                                                                                             |
| VPD Lab Message Patient Identifier                                                                             | VPD Lab Message Patient Identifier                                                                                                                                                                                                                           |                                                                                                                                                                             |
| VPD Lab Message Observation Identifier                                                                         | VPD Lab Message Observation Identifier                                                                                                                                                                                                                       |                                                                                                                                                                             |
| VPD Lab Message Observation Value                                                                              | VPD Lab Message Observation Value                                                                                                                                                                                                                            |                                                                                                                                                                             |
| Specimen Collection Date                                                                                       | Date of specimen collection                                                                                                                                                                                                                                  |                                                                                                                                                                             |
| Specimen Source                                                                                                | The medium from which the specimen originated                                                                                                                                                                                                                |                                                                                                                                                                             |
| Numeric Test Result                                                                                            | Numeric, quantitative result of the test(s) performed for this case                                                                                                                                                                                          |                                                                                                                                                                             |
| Numeric Test Result Units                                                                                      | Numeric, quantitative result unit of the test(s) performed for this case                                                                                                                                                                                     |                                                                                                                                                                             |
| Chest X-ray result                                                                                             | Chest X-ray result                                                                                                                                                                                                                                           |                                                                                                                                                                             |
| Was the rash generalized                                                                                       | Was the rash generalized                                                                                                                                                                                                                                     |                                                                                                                                                                             |
| Reason for Hospitalization                                                                                     | If the subject was hospitalized because of this event, indicate the reason(s).                                                                                                                                                                               |                                                                                                                                                                             |

Label/Short Name

AGEMM  
AGEYY  
CDCNUM  
CITY  
COUNTY  
DATECOMP  
DOB  
ETHNICITY  
FDANUM  
FNAME  
LNAME  
OCCUPAT  
RACE  
SEX  
STATE  
STEPINUM  
STLABNUM  
FEVER  
NAUSEA  
VOMIT  
DIARRHEA  
VISBLOOD  
CRAMPS  
HEADACHE  
MUSCPAIN  
CELLULIT  
BULLAE  
SHOCK  
OTHER  
MAXTEMP  
CENFAR  
NUMSTLS  
CELLSITE  
BULLSITE  
OTHSPEC2  
AMPMSYMP  
ANTIBYN  
Descant1  
Descant2  
Descant3  
ANTNAM01  
ANTNAM02  
ANTNAM03  
ANTNAM04  
BEGANT1

BEGANT2  
BEGANT3  
BEGANT4  
CDCISOL  
DATEADMN  
DATEDIED  
DATEDISC  
DATESYMP  
DURILL  
ENDANT1  
ENDANT2  
ENDANT3  
ENDANT4  
GSURGTYP  
HEMOTYPE  
HHSYMP  
HOSPYN  
IMMTYPE  
LIVTYPE  
MALTYPE  
MISYMP  
OTHCONSP  
PATDIE  
PEPULCER  
ALCOHOL  
DIABETES  
INSULIN  
GASSURG  
HEART  
HEARTFAL  
HEMOTOL  
IMMUNOD  
LIVER  
MALIGN  
RENAL  
RENTYPE  
OTHCOND  
TRTANTI  
TRTCHEM  
TRTRADIO  
TRTSTER  
TRTIMMUN  
TRTACID  
TRTULCER  
SEQDESC  
SEQUELAE  
TRTACISP

TRTANTSP  
TRTCHESP  
TRTIMMSP  
TRTRADSP  
TRTSTESP  
TRTULCSP  
DATESPEC  
SPECIESNAME  
SITE  
STATECON  
SOURCE  
OTHORGAN  
SPECORGAN  
AMBTMFC  
AMNTCONS  
AMPMCONS  
DATEAMBT  
DATEFECL  
DATEH2O  
DATEHAR1  
DATEHAR2  
DATERAIN  
DATESALN  
DATESEAR  
FECALCNT  
H2OSALIN  
HARVSIT1  
HARVSIT2  
HARVST01  
HARVST02  
HARVSTS1  
HARVSTS2  
HHCONSUM  
IMPROPER  
MAMTEMP  
MICONSUM  
RAINFALL  
RESTINV  
SEADISSP  
SEADIST  
SEAHARV  
SEAIMPOR  
SEAIMPSP  
SEAOBT  
SEAOBTSP  
SEAPREP  
SEAPRSP

SH2OTEMP  
SH2OTMFC  
SOURCES  
SHIPPERS  
TAGSAVA  
TYPESEAF  
HARVESTSTATE  
HARVESTREGION  
TRVROTHR  
AMPMEXP  
HANDLING  
SWIMMING  
WALKING  
BOATING  
CONSTRN  
BITTEN  
ANYWLIFE  
BODYH2O  
CONSTRN  
DATEEXPO  
DATEWHI1  
DATEWHI2  
DATEWHI3  
DATEWHO1  
DATEWHO2  
DATEWHO3  
FISHSP  
H2OCOMM  
H2OTYPE  
HHEXPOS  
LOCEXPOS  
MIEXPOS  
OTHEREXP  
OTHERH2O  
OTHSHSP  
OUTBREAK  
OUTBRKSP  
CLAMS  
CRAB  
LOBSTER  
MUSS  
OYSTER  
SHRIMP  
CRAY  
OTHSH  
FISH  
RCLAM

RCRAB  
RLOBSTER  
RMUSS  
ROYSTER  
RSHRIMP  
RCRAY  
ROTHSH  
RFISH  
DATECLAM  
DATECRAB  
DATELOBS  
DATEMUSS  
DATEOYSTER  
DATESHRI  
DATECRAY  
DATEOTHSH  
DATEFISH  
SPECEXPO  
STRESID  
TRAVEL  
WHERE01  
WHERE02  
WHERE03  
WOUNDEXP  
WOUNDSP  
Culture Confirmation  
CIDT Results  
CIDT Species Results  
CIDT Test Name  
Dining Partner Seafood Consumption

Ill Dining Partners  
Exposure related to occupation  
Specify Different Exposure Window

PulseNet ID  
WGS ID Number

## Description

Age in months

Age in years

CDC Number

City

County

Date completing form

Date of birth

Hispanic or Latino origin?

FDA Number

First 3 letters of first name

First 3 letters of last name

Occupation

Race

Sex

State of exposure (usually reporting state)

State Number

State Lab Number

Fever

Nausea

Vomiting

Diarrhea

Bloody stool

Abdominal cramps

Headache

Muscle Pain

Cellulitis

Bullae

Shock

Other

Symptom: Maximum temp of fever

Fever measured in units of C or F

Symptom: # of stools/24 hours

Symptom: Site of cellulitis

Symptom: Site of Bullae

Symptom: Specify other Symptoms

Seafood Investigation: Onset in am or pm

Did patient receive antibiotics?

Name of 1st Antibiotic

Name of 2nd Antibiotic

Name of 3rd Antibiotic

Name of 1st Antibiotic (old)

Name of 2nd Antibiotic (old)

Name of 3rd Antibiotic (old)

Name of 4th Antibiotic (old)

Date began Antibiotic #1

Date began Antibiotic #2  
Date began Antibiotic #3  
Date began Antibiotic #4  
CDC Isolate No.  
Date admitted to hospital  
Date of death  
Date of discharge from hospital  
Date of symptom onset  
# days ill  
Date ended Antibiotic #1  
Date ended Antibiotic #2  
Date ended Antibiotic #3  
Date ended Antibiotic #4  
Pre-existing: Type of gastric surgery  
Pre-existing: Type of hemotological disease  
Hour of symptom onset  
Hospitalized?  
Pre-existing: Type of Immunodeficiency  
Pre-existing: type of liver disease  
Pre-existing: Type of Malignancy  
Minute of symptom exposure  
Pre-existing: Type of Other condition  
Did patient die?  
Pre-existing: Peptic ulcer  
Pre-existing: Alcoholism  
Pre-existing: Diabetes  
Pre-existing: on insulin?  
Pre-existing: Gastric surgery  
Pre-existing: Heart disease  
Pre-existing: Heart failure?  
Pre-existing: Hematologic disease  
Pre-existing: Immunodeficiency  
Pre-existing: Liver disease  
Pre-existing: Malignancy  
Pre-existing: Renal disease  
Pre-existing: Type of renal disease  
Pre-existing: Other  
Type of treatment received: antibiotics  
Type of treatment received: chemotherapy  
Type of treatment received: radiotherapy  
Type of treatment received: systemic steroids  
Type of treatment received: immunosuppressants  
Type of treatment received: antacids  
Type of treatment received: H2 Blocker or other ulcer medication  
Describe Sequelae  
Sequelae?  
If previously treated with Antacids, specify

If previously treated with Antibiotics, specify

If previously treated with chemotherapy, specify

If previously treated with immunosuppressants, specify

If previously treated with radiotherapy, specify

If previously treated with steroids, specify

If treated with ulcer meds, specify

Date specimen collected

Species

If other source, specify site from which Vibrio was isolated

Was Species confirmed at State PH Lab?

Specimen source

Other organism isolated from specimen?

Specify other organism isolated

Seafood Investigation: Maximum ambient temp units - F or C

Seafood Investigation: Amount of shellfish consumed

Seafood Investigation: Shellfish consumed in am or pm

Seafood investigation: Date ambient temp measured

Seafood Investigation: Date of fecal count

Seafood Investigation: Date water temp measured

Seafood Investigation: Date of harvest #1

Seafood Investigation: Date of harvest #2

Seafood Investigation: Date total rain fall recorded

Seafood Investigation: Date salinity measured

Seafood Investigation: Date restaurant rec'd seafood

Seafood Investigation: Fecal Coliform Count

Seafood Investigation: Results of Salinity test

Seafood Investigation: Harvest Site #1

Seafood Investigation: Harvest Site #2

Seafood Investigation: Status of Harvest Site #1

Seafood Investigation: Status of Harvest Site #2

Seafood Investigation: Specify if Status for Harvest Site #1 = other

Seafood Investigation: Specify if Status for Harvest Site #2 = other

Seafood Investigation: Hour of seafood consumption

Seafood Investigaion: Improper Storage?

Seafood Investigation: Maximum ambient temp

Seafood Investigation: Minute of seafood consumption

Seafood Investigation: Total rainfall in Inches

Seafood Investigation: Investigation of Restaurant?

Seafood Investigation: Specify how shellfish distributed

Seafood Investigation: How is shellfish distributed?

Seafood Investigation: Was shellfish harvested by patient or friend?

Seafood Investigation: Was seafood imported?

Seafood Investigation: Specify country of Import

Seafood Investigation: where was seafood obtained?

Seafood Investigation: Specify from where seafood was obtained

Seafood Investigation: How was seafood prepared?

Seafood Investigation: Specify how seafood was prepared (if other)

Seafood Investigation: Surface water temperature  
Surface water temp units in F or C?  
Sources of seafood  
Shippers who handled suspected seafood (certification numbers)  
Seafood investigation: Are tags available from suspect lot?  
Seafood investigation: Type of shellfish consumed  
State in which seafood was harvested  
Region in which seafood was harvested  
Cholera, reason for travel: specify if other  
Seafood Investigation: Exposure to seawater in am or pm  
Exposure: handling/cleaning seafood  
Exposure: Swimming/diving/wading  
Exposure: Walking on beach/shore/fell on rocks/shells  
Exposure: Boating/skiing/surfing  
Exposure: Construction/repairs  
Exposure: Bitten/stung  
Exposure: Contact with other marine/freshwater life  
Exposure: Exposure to a body of water  
Exposure to water via construction  
Exposure: Date of exposure to seawater  
Date traveled/entered destination #1  
Date traveled/entered destination #2  
Date traveled/entered destination #3  
Date left/returned home #1  
Date left/returned home #2  
Date left/returned home #3  
Type of fish  
Exposure: Comments on water exposure  
Exposure: Type of water exposure  
Exposure: Hour of seawater exposure  
Exposure: location of water exposure  
Exposure: Minute of seawater exposure  
Exposure: Other exposure  
Exposure: Exposed to other water not listed?  
Specify other shellfish consumed  
Is case part of outbreak?  
If part of an outbreak, Specify outbreak  
Consumption: clams  
Consumption: crab  
Consumption: lobster  
Consumption: mussels  
Consumption: oysters  
Consumption: shrimp  
Consumption: crawfish  
Consumption: other shellfish  
Consumption: other fish  
Raw consumption: clams

Raw consumption: crab  
Raw consumption: lobster  
Raw consumption: muss  
Raw consumption: oyster  
Raw consumption: shrimp  
Raw consumption: crawfish  
Raw consumption: other shellfish  
Raw consumption: other fish  
Date of seafood consumption: clams  
Date of seafood consumption: crab  
Date of seafood consumption: lobster  
Date of seafood consumption: mussels  
Date of seafood consumption: oysters  
Date of seafood consumption: shrimp  
Date of seafood consumption: crawfish  
Date of seafood consumption: other shellfish  
Date of seafood consumption: other fish  
Specify other seawater/shellfish dripping exposure (if other)  
State of residence  
Exposure to travel outside home state in previous 7 days?  
Travel destination #1  
Travel destination #2  
Travel destination #3  
Did patient incur a wound before/during exposure?  
If patient incurred wound before/during exposure, describe wound  
Was Vibrio confirmed by culture?  
Was there a positive CIDT result?  
Name of species identified by CIDT  
Name of CIDT test used if applicable  
Did dining partners consume same seafood?

Did dining partners who consumed the same seafood become ill?

Was your exposure related to your occupation?

If the epidemiologic exposure window used by the jurisdiction is different from that stated in the exposure questions, specify the time interval in days here. Otherwise, leave blank.

State lab ID submitted to PulseNet

Whole Genome Sequencing (WGS) ID Number

Value Set Code. Search in PHIN VADS using the following link  
(<https://phinvads.cdc.gov/vads/SearchHome.action>)

CDC Priority (Legacy)

N/A

P

N/A

N/A



CDC Priority (New)

