

Cryptosporidiosis

COUNTY

FOR STATE USE ONLY

____/____/____ case report

- confirmed
- presumptive
- suspect

____/____/____ interstate

Date investigation initiated _____

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

_____ e-mail address _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

- Lab Infection Control Practitioner
- Physician _____

Name _____

Phone _____ Date ____/____/____
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX
 female male

HISPANIC yes no unknown

RACE
 White American Indian
 Black Asian/Pacific Islander
 unknown refused to answer
 other _____

DATE OF BIRTH ____/____/____
m d y

or, if unknown, AGE _____

Worksites/school/day care center _____

Occupations/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic yes no unk
if yes, ONSET on ____/____/____
m d y

Check all that apply:
diarrhea yes no unk
if yes, ONSET on ____/____/____
m d y

abdominal cramps yes no unk

nausea yes no unk

vomiting yes no unk

loss of appetite yes no unk

weight loss yes no unk

fever oral rectal

highest temp recorded °F _____

Hospitalized: yes no unk

name of hospital _____

date of admission ____/____/____
m d y

date of discharge ____/____/____
m d y

Transferred to/from another hospital:
 yes no unk

Is the person immunocompromised?
 yes no unk

Outcome: survived died unk
date of death ____/____/____

LABORATORY DATA

Lab confirmed yes no

if yes, Lab _____

Specimen:
 stool
 other _____

Specimen collected ____/____/____
m d y

Confirmed at PHL:
 yes no unk

EPI-LINKAGE

During the exposure period, was the patient...

associated with a known outbreak? yes no unk

a close contact of a **confirmed** or **presumptive** case? yes no unk

Has the above case been reported? yes not yet

Specify nature of contact:

household sexual daycare _____

if yes to any question, specify relevant names, dates, places, etc:

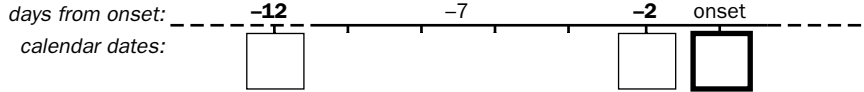
Does the case know about anyone else with a similar illness? yes no could not be interviewed
if yes, give names, onset dates, contact information, and other details.



INFECTION TIMELINE

EXPOSURE PERIOD

Enter onset date in heavy box.
Count backwards to figure probable exposure period.



Most persons shed infectious oocysts in stool during the period of diarrhea. Shedding may continue in some patients for several days—possibly longer.

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Skip this section if the case was already epi-linked.

- no risk factors could be identified
- patient could not be interviewed

POSSIBLE SOURCES:

- yes no
- a raw milk
 - b unpasteurized apple juice/cider
 - c eating shellfish
 - d eating at restaurants
 - e eating at other gatherings (potlucks, events)

- yes no
- f attends or works in daycare center/nursery
 - g contact with farm animals
 - h contact with sick pets or other animals
 - r work with animal products, research, slaughter house, veterinary medicine
 - i travel outside county to _____
 - j contact with other people with diarrhea
 - k drinking untreated surface water
 - l recreational water (pools, water slides, lakes,...)
 - m homosexual contact
 - n _____

- o travel outside U.S.
departure date ___/___/___
return date ___/___/___
- p other travel
departure date ___/___/___
return date ___/___/___

SOURCE OF HOME WATER

- unknown
- private source
 well
 surface _____
- public/community system
name of company: _____
- _____

Provide details about possible sources and risk factors

CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER

name	age	occupation	sick?			onset date	education provided			comments
			yes	no	unk		yes	no	unk	
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

If the patient attends daycare or nursery school,

Contact person/phone:

Is the patient in diapers? yes no

Are other children or staff ill? yes no

OTHER FOLLOW-UP. Provide details as appropriate.

- hygiene education provided
- work or daycare restriction for case
- daycare inspection
- follow-up of other household member(s)
- testing of home/other water supply
- _____

ADMINISTRATION

Remember to copy patient's name to the top of this page.

Case report sent to OHS on ___/___/___

Completed by _____ Date _____ Phone _____ Investigation sent to OHS on ___/___/___

