Cryptosporidiosis Case Report Worksheet

Name: ________________________ **CDRSS Number:** ____________

Interviewer: ________________________ **Date Completed:** ____________

Information provided by ________________________ **Relation to Case:** ____________

DEMOGRAPHICS

Gender: ☐ Male ☐ Female

Date of Birth ____/____/______

Hispanic: ☐ Yes ☐ No ☐ Unk

Race:

☐ White ☐ Native Amer.

☐ Black ☐ Asian/Pac. Islander

☐ Other ☐ Unknown

Occupation/Setting:

Daycare worker/attendee: ☐ Yes ☐ No ____________

Healthcare provider: ☐ Yes ☐ No ____________

Foodhandler: ☐ Yes ☐ No ____________

Group Living: ☐ Yes ☐ No ____________

Attend or work in a school/camp: ☐ Yes ☐ No ____________

If yes to any above, did patient work/attend while ill? ☐ Yes ☐ No

If the case is a food handler, health care worker or works for or attends a daycare, obtain details about site, job description, dates worked/attended during communicable period. For exclusion guidance see recommendations in the NJDOH disease chapter.

CLINICAL INFORMATION

Symptomatic: ☐ Yes ☐ No

If yes: Onset date/time: ____/_____/____________ __________

Resolution date/time: ____/_____/________ __________

First/predominant symptom__________________________

Diarrhea (3 loose stools/24 hrs.):	☐ Yes	☐ No	onset date/time:
Diarrhea lasting ≥ 72 hours	☐ Yes	☐ No	onset date/time:
Abdominal pain/cramps:	☐ Yes	☐ No	onset date/time:
Nausea:	☐ Yes	☐ No	onset date/time:
Vomiting:	☐ Yes	☐ No	onset date/time:
Fever:	☐ Yes	☐ No	onset date/time:
Headache:	☐ Yes	☐ No	onset date/time:
Loss of appetite:	☐ Yes	☐ No	onset date/time:

Other symptoms:
____
____
____

Physician Name: ____________________

Physician Phone: ____________________

Antibiotic treatment: ☐ **Yes** ☐ **No**

If yes, name of antibiotic and dates taken:

____

____/____/_____ **to** ____/____/_____

Hospitalized: ☐ **Yes** ☐ **No**

Name of Hospital____________________

Date of Admission: _____/_____/_______

Date of Discharge: _____/_____/________

ED visit only-date: _____/_____/________

Outcome: Died: ☐ **Yes** ☐ **No**

If yes, date of death: _____/_____/_______

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Y N
☐ ☐ Travel outside the U.S. 2 weeks prior to symptom onset
Where: _______________________________
Dates: ____/____/___ to ____/____/_____

Y N
☐ ☐ Travel within the U.S. 2 weeks prior to symptom onset
Where: _______________________________
Dates: ____/____/___ to ____/____/_____

EXPOSURE SOURCES (use 2 weeks prior to symptom onset): Date Range: _________________to__________________

Y N

☐ ☐ **Recreational water exposures?**

If yes, specify type: ☐ Natural freshwater (i.e. lake) ☐ Natural saltwater (i.e. ocean) ☐ Pool/spa ☐ Water park/fountains

Details including date: ____

____

Did person touch water? ☐ Yes ☐ No Wade? ☐ Yes ☐ No Swim? ☐ Yes ☐ No

Accidentally or intentionally swallow water? ☐ Yes ☐ No ☐ Unknown

☐ ☐ **Hiking/Camping/Backpacking?**

If yes: Location ____

Did person drink river or stream water? ☐ Yes ☐ No

If yes: Was water treated or filtered? Check all methods that apply ☐ Boiled ☐ Filtered ☐ Disinfection ☐ Unknown

☐ ☐ **Yardwork/composting (w/manure and/or fertilizer)?**

☐ ☐ **Contact with any animals (including farm animals and pets)?**

Animals encountered: ☐ Puppies ☐ Kittens ☐ Dogs ☐ Cats ☐ Other *(specify)* ____________________________

☐ ☐ **Visit/Work on a farm, petting zoo, county/state fair, rodeo, dairy?**

Animals encountered: *(specify)* ____

☐ ☐ **Contact with animal waste/manure?**

☐ Cat ☐ Dog ☐ Farm animal ☐ Other *(specify)* ____

If yes, were any animals sick with diarrhea? ☐ Yes ☐ No ☐ Unknown

Details of exposure ____

Ask if individual consumed the following foods or performed the following actions WITHIN THE PAST 2 WEEKS.

Y N U

☐ ☐ ☐ **Consumed raw or unpasteurized milk?**

Was milk unrefrigerated for >1 hour, including during transport? ☐ Yes ☐ No ☐ Unknown

☐ ☐ ☐ **Other unpasteurized milk products (cheese, cream, ice cream?)** _________________________

☐ ☐ ☐ **Unpasteurized juice or cider?** ____

☐ ☐ ☐ **Raw fruits or vegetables (store bought/home grown)?** *(specify)*____

If yes: Date(s) of consumption: ____

If yes to any of above, was any food eaten in a restaurant? ☐ Yes ☐ No If yes, provide restaurant name and location

Name: _________________________ Location: _______________________________ Date: _________________

Name: _________________________ Location: _______________________________ Date: _________________

Name: _________________________ Location: _______________________________ Date: _________________

☐ ☐ ☐ **Water source?**

☐ Individual well ☐ Shared well ☐ Public water ☐ Bottled water ☐ Other___________________

If well: How far from septic system is well located? ________________ Depth of well? __________

Recently drilled? ☐ Yes No ☐ Is well water tested? ☐ Yes No ☐ Is well water treated? ☐ Yes No ☐

☐ ☐ ☐ **Consumed filtered water?**

If yes: ☐ Filter on faucet (e.g. Brita) ☐ Filter on pitcher for drinking water ☐ Whole house filter system

Does the case know anyone with a similar illness, including those he/she lives with? ☐ **YES** ☐ **NO**

If yes, fill out table below for each ill household member and contact.

ILL HOUSEHOLD MEMBERS/ OTHER ILL CONTACTS

Name	Age	Relation to case	Symptoms	Onset date	Phone Number
___________________	______	______________	___________________	____/____/____	_________________
___________________	______	______________	___________________	____/____/____	_________________
___________________	______	______________	___________________	____/____/____	_________________

If the case or contact is a food handler, healthcare worker or works for or attends a daycare, provide details about site, job description, dates worked/attended during communicable period. For exclusion guidance see recommendations in the NJDOH disease chapter.

____

____

____

____

ACTIONS TAKEN

☐ Interviewed w/worksheet

☐ Patient could not be interviewed (reason):

____

Dates interview attempted

☐______________ ☐_____________ ☐_____________

☐ Spoke to healthcare provider

☐ Daycare inspection/education

☐ Follow-up of ill contacts

☐ Refer for restaurant inspection

☐ Work or daycare restriction for case

☐ Entered into CDRSS

☐ Patient education