Washington State Department of Health

Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

Giardiasis

County

LHJ Use **ID** _____
☐ **Reported to DOH** **Date** ___/___/___
LHJ Classification ☐ **Confirmed**
☐ **Probable**
By: ☐ **Lab** ☐ **Clinical**
☐ **Other:** _____
Outbreak # (LHJ) _____ **(DOH)** _____

DOH Use ***ID*** _____
Date Received ___/___/___
DOH Classification
☐ ***Confirmed***
☐ ***Probable***
☐ ***No count; reason:***

REPORT SOURCE

Initial report date ___/___/___
Reporter (check all that apply)
☐ Lab ☐ Hospital ☐ HCP
☐ Public health agency ☐ Other
OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Reporter name _____
Reporter phone _____
Primary HCP name _____
Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
Address _____ ☐ Homeless
City/State/Zip _____
Phone(s)/Email _____
Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name _____
Phone _____
Occupation/grade _____
Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
Gender ☐ F ☐ M ☐ Other ☐ Unk
Ethnicity ☐ Hispanic or Latino
☐ Not Hispanic or Latino
Race (check all that apply)
☐ Amer Ind/AK Native ☐ Asian
☐ Native HI/other PI ☐ Black/Afr Amer
☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ___/___/___ ☐ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y	N	DK	NA	
☐	☐	☐	☐	**Diarrhea** Maximum # of stools in 24 hours: ____
☐	☐	☐	☐	**Pale, greasy or odorous stool**
☐	☐	☐	☐	**Abdominal cramps or pain**
☐	☐	☐	☐	**Weight loss with illness**
☐	☐	☐	☐	**Bloating or gas**

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Immunosuppressive therapy or disease

Hospitalization

Y	N	DK	NA	
☐	☐	☐	☐	Hospitalized for this illness

Hospital name _____
Admit date ___/___/___ Discharge date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	Died from illness Death date ___/___/___
☐	☐	☐	☐	Autopsy

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	***Giardia lamblia*** **antigen positive by immunodiagnostic test, e.g. EIA (stool)**
☐	☐	☐	☐	***Giardia lamblia*** **cysts demonstrated (stool)**
☐	☐	☐	☐	***Giardia lamblia*** **trophozoites demonstrated**

NOTES

Case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered

Washington State Department of Health **Case Name:** _____

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

	Exposure period		onset	***Contagious period***
Days from onset:	-25	-3		weeks to months
Calendar dates:				

EXPOSURE (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
  Out of: ☐ County ☐ State ☐ Country
  Destinations/Dates: _____
  _____
- ☐ ☐ ☐ ☐ Does case know anyone else with similar symptoms or illness?
- ☐ ☐ ☐ ☐ Contact with lab confirmed case
  ☐ Household ☐ Sexual
  ☐ Needle use ☐ Other: _____
- ☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed human case**
- ☐ ☐ ☐ ☐ Contact with diapered or incontinent child or adult
- ☐ ☐ ☐ ☐ Group meal (e.g. potluck, reception)
- ☐ ☐ ☐ ☐ Food from restaurants
  Restaurant name/location: _____
  _____
- ☐ ☐ ☐ ☐ Source of home drinking water known
  ☐ Individual well ☐ Shared well
  ☐ Public water system ☐ Bottled water
  ☐ Other: _____
- ☐ ☐ ☐ ☐ Drank untreated/unchlorinated water (e.g. surface, well)
- ☐ ☐ ☐ ☐ Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)
- ☐ ☐ ☐ ☐ Farm or dairy residence or work
- ☐ ☐ ☐ ☐ Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse)
- ☐ ☐ ☐ ☐ Exposure to pets
  Was the pet sick ☐**Y** ☐**N** ☐**DK** ☐**NA**
- ☐ ☐ ☐ ☐ Zoo, farm, fair or pet shop visit
- ☐ ☐ ☐ ☐ Any contact with animals at home or elsewhere
  Dog or puppy ☐**Y** ☐**N** ☐**DK** ☐**NA**
- ☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor)
  Specify country: _____
- ☐ ☐ ☐ ☐ Any type of sexual contact with others during exposure period:
  # female sexual partners: _____
  # male sexual partners: _____

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

Most likely exposure/site: _____ **Site name/address:** _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

PATIENT PROPHYLAXIS / TREATMENT

PUBLIC HEALTH ISSUES

Y N DK NA

- ☐ ☐ ☐ ☐ Employed as food worker
- ☐ ☐ ☐ ☐ Non-occupational food handling (e.g. potlucks, receptions) during contagious period
- ☐ ☐ ☐ ☐ Employed as health care worker
- ☐ ☐ ☐ ☐ Employed in child care or preschool
- ☐ ☐ ☐ ☐ Attends child care or preschool
- ☐ ☐ ☐ ☐ Household member or close contact in sensitive occupation or setting (HCW, child care, food)
- ☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

- ☐ Consider excluding case in sensitive occupation until diarrhea ceases
- ☐ Consider excluding symptomatic contacts in sensitive occupations or situations until diarrhea ceases
- ☐ Work or child care restriction
- ☐ Test symptomatic contacts
- ☐ Hygiene education provided
- ☐ Restaurant inspection
- ☐ Child care inspection
- ☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____

Giardiasis: case defining variables are in **bold.** Answers are: Yes, No, Unknown to case, Not asked /Not answered