

**PATIENT IDENTIFIERS (Please tear off this page before sending the COVIS case report form to CDC. Patient identifiers should not be transmitted to CDC)**

Patient’s Name:

Patient’s Address:

Telephone:

Physician’s Name:

Telephone:

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## CHOLERA AND OTHER VIBRIO ILLNESS SURVEILLANCE REPORT

OMB 0920-0728

REPORTING HEALTH DEPARTMENT			SEND COMPLETED REPORT TO STATE INFECTION CONTROL State will forward to: covidresponse@cdc.gov E-fax: 404-235-1735 Centers for Disease Control and Prevention Enteric Diseases Epidemiology Branch 1600 Clifton Road, MS C09 Atlanta, GA 30333
State	City	County/Parish	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

## 1. PATIENT CASE INFORMATION

1. First 3 letters of patient's last name: ____ ____ ____			2. Sex:      M              F              Unk		
3. Date of birth (MM/DD/YYYY): _____		4. Age: _____ YEARS              MONTHS		3. NNDSS case ID	
				4. Case state ID ( <i>required</i> )	
5. Race:              American Indian/Alaska Native              White Black or African American              Other Native Hawaiian or other Pacific Islander              Unknown/not provided Asian			6. Ethnicity:              Hispanic/Latino Not Hispanic/Latino              Unknown/not provided		
			7. Occupation: _____		

## 2. LABORATORY INFORMATION

**Use the *Vibrio* Species key to indicate which species were positively identified by culture or CIDT result as applicable.**

Vibrio Species Key:

*V. cincinnatiensis* —CIN

*Grimontia hollisae*—HOL

*Vibrio*—species not identified. ed—NID

*V. alginolyticus*—ALG

*Photobacterium damsela* subsp. *Damsela* —DAM

*V. metschnikovii*—MET

Other—OTH (Specify below)

*V. cholerae* O1—CH1

*V. fluvialis*—FLU

*V. mimicus*—MIM

Multiple species—MUL (Specify below)

*V. cholerae* O139—CH3

*V. juvenalis*—FLU

*V. parahaemolyticus*—PAR

Epidemiologically linked to a laboratory detected case (no lab results)

*V. cholerae* non-O1, non-O139—CHN

*V. furnissii*—FUR

*V. vulnificus*—VUL

**Laboratory results (If more than one specimen is tested, complete one row per specimen. If more than two specimens were tested, please check here ☐ and attach additional sheet. CIDT indicates a culture-independent diagnostic test.)**

1. <u>Specimen one:</u> Date collected: _____ (MM/DD/YY) Received at public health laboratory? Yes No Unk If yes, State lab ID: _____				
Specimen source:	<u>Culture</u> , result:		<u>CIDT</u> , result: Pos Neg Unk Not Done	
	Pos	Neg	Unk	Not Done
Specimen Site:	If positive, species identified: _____		If positive, species identified: _____	
If Other, specify:	If species identified as multiple or other, specify:		Name/type of diagnostic test used:	
	_____		_____	
	_____		If species identified as multiple or other, please specify: _____	

2. <u>Specimen two</u> : Date collected: _____ (MM/DD/YY)		Received at public health laboratory? Yes No Unk		If yes, State lab ID: _____	
Specimen Source:	<u>Culture</u> , result:	<u>CIDT</u> , result: Pos Neg Unk Not Done			
	Pos Neg Unk Not Done	If positive, species identified: _____			
Specimen Site:	If positive, species identified: _____	Name/type of diagnostic test used: _____			
	If species identified as multiple or other, specify: _____	If species identified as multiple or other, please specify: _____			

3. If other non-*Vibrio* organism(s) isolated from same specimen, list:

**Complete only if isolate is *Vibrio cholerae* O1 or O139:**

4. <u>Serotype</u> :	Inaba	Ogawa	5. <u>BioType</u> :	El Tor	Classical	Not done	Unk
	Hikojima	Not done	Unk	6. <u>Toxigenic</u> :	Yes	No	Not done
							Unk

**3. CLINICAL INFORMATION**

1. Date illness began (MM/DD/YY): _____	4a. Admitted to a hospital overnight for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
2. Duration of illness (Days): _____	4b. If yes, admission date (MM/DD/YY): _____		
3a. Did patient die?   Yes   No   Unknown 3b. If yes, date (MM/DD/YY): _____	4c. Discharge date (MM/DD/YY): _____		
5. Did patient take an antibiotic as treatment for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, name(s) of antibiotic(s):  1. _____ 2. _____ 3. _____		Date began antibiotic (MM/DD/YY): _____ _____ _____	Date ended antibiotic: (MM/DD/YY): _____ _____ _____

Signs and symptoms:	Yes	No	Unk	Medical history (optional for probable cases):	Yes	No	Unk
Vomiting				Alcoholism			
Diarrhea				Diabetes			
Visible blood in stools				Gastric surgery			
Abdominal cramps				Heart disease (If yes, Heart failure?   Y   N   U )			
Fever (>100.4F or 38 C)				Hematologic disease			
Muscle pain				Immunosuppressive condition/immunodeficiency			
Septic shock				Immunosuppressive therapy			
Cellulitis (Site _____)				Liver disease			
Bullae (Site _____)				Cancer			
Sequelae (e.g. amputation, skin graft) (Type: _____)				Kidney disease			
Other (ear pain, discharge, rash, etc.): _____				Took antacids or ulcer medication in past 30 days (Type/Frequency: _____)			
Additional signs and symptoms comments:				Peptic ulcer			
				Other: _____			
				If yes to any of the above conditions, specify type:			

**4. EPIDEMIOLOGY SECTION**

1. Was this case part of an outbreak?   Yes   No   Unk		
2. If yes, please describe (include NORS ID if available): _____		
3. PulseNet cluster code (if available): _____		
4. Did patient travel outside their home state in the 7 days before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
5. Did patient travel to another country in the 7 days before illness onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
6. If yes, list destinations and dates*:	Date arrived (MM/DD/YY)	Date left (MM/DD/YY)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

\*Please list any additional travel destinations or information in the comments section on page 5.

Cholera exposure (Only complete if laboratory result includes toxigenic V. cholerae O1 or O139.)

1. Was patient exposed to a person with cholera? ☐ Yes ☐ No ☐ Unknown

2. If patient traveled outside of U.S., what was the reason for travel?

To visit relatives/friends

Tourism

Medical/Disaster Relief

Other: \_\_\_\_\_

Business

Military

Unknown

3. Has the patient ever received a cholera vaccine? Yes No Unknown

4. If yes, most recent vaccination date (MM/DD/YYYY) : \_\_\_\_\_

Seafood consumption

1. Only indicate consumption during the 7 days before illness began.

Type of Seafood	Eaten?	Eaten raw?	Multiple dates?	Last date consumed	Type of Seafood	Eaten?	Eaten raw?	Multiple dates?	Last date consumed
	Y N U	Y N U	Y N U	(MM/ DD/ YY)		Y N U	Y N U	Y N U	(MM/ DD/ YY)
Clams				_____	Shrimp				_____
Mussels				_____	Crawfish				_____
Oysters				_____	Lobster				_____
Scallops				_____	Crabs				_____
Other shellfish				_____	Fish				_____

Further description of seafood: \_\_\_\_\_

2. Did any dining partners consume the same seafood? Yes No Unk

3. If yes, did any become ill? Yes No Unk

Water exposure

In the 7 days before illness began, was patient's skin exposed to any of the following?

1a. A body of water (ocean, lake, etc.): Yes No Unknown

1b. If yes, specify name of body of water: \_\_\_\_\_

1c. If exposed to water, indicate type: Salt Fresh Brackish Other, specify: \_\_\_\_\_ Unknown

2. Drippings from raw or live seafood, including handling/cleaning: Yes No Unknown

3. Marine life, including stings/bites : Yes No Unknown

4. Date of most recent exposure: (MM/DD/YY): \_\_\_\_\_

5. If yes to any of the above exposures, was this an occupational exposure? Yes No Unknown

6a. If patient's skin was exposed to any of the above, did patient sustain a wound or have a pre-existing wound?

☐ Yes, sustained a wound

Yes, had pre-existing wound

Yes, uncertain if old/new

No

Unknown

6b. If Yes, describe how wound occurred and site on body: \_\_\_\_\_

Additional comments: \_\_\_\_\_

Lost to follow-up

Person completing section 1-4: \_\_\_\_\_

Date completed (MM/DD/YY): \_\_\_\_\_

Title/Agency: \_\_\_\_\_

Tel: \_\_\_\_\_

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**5. SEAFOOD INVESTIGATION (Please complete one copy of this page for each type of seafood ingested and investigated, and identify investigation page number below. Completion of this page is optional for probable cases.)**

Seafood Investigation page \_\_\_\_ of \_\_\_\_

**Product information**

1. Type of seafood being investigated: \_\_\_\_\_ 2. Date consumed (MM/DD/YY): \_\_\_\_\_

3. Amount consumed (e.g., 6 oysters, 1 filet, 5oz, etc.): \_\_\_\_\_

4. How prepared: Fully cooked ☐ Undercooked ☐ Raw ☐ Unknown

5. Additional relevant information on product preparation (e.g., specific variety of seafood consumed and plating: \_\_\_\_\_

6. Was this fish or shellfish harvested by the patient or a friend of the patient? Yes No ☐ Unknown

(If yes, skip to source information questions. If no, complete entire page as possible.)

**Commercial vendor Information (only complete if product consumed at a commercial establishment)**

1. Name of restaurant, oyster bar, or food store: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_

City/State: \_\_\_\_\_

2. Type of establishment: ☐ Oyster bar or restaurant☐ Seafood market☐ Unknown☐ Truck or roadside vendor☐ Other (specify): \_\_\_\_\_☐ Food store

3. Date restaurant or food outlet received seafood (MM/DD/YY): \_\_\_\_\_

4. Was the seafood imported from another country? ☐ Yes ☐ No ☐ Unknown

If yes, name of country: \_\_\_\_\_

5. Was a restaurant or outlet environmental assessment conducted? ☐ Yes ☐ No ☐ Unknown6. Was there evidence of improper handling or storage? ☐ Yes ☐ No ☐ Unknown

If yes (check all that apply): Holding temperature violation Cross-contamination Co-mingling of live and dead shellfish

☐ Improper storage ☐ Other: \_\_\_\_\_

7. If oysters, clams, or mussels were eaten, how were they received by the retail outlet?

☐ Live shellstock ☐ Processed animal with shell attached ☐ Shucked meat ☐ Unknown ☐ Other (specify): \_\_\_\_\_
**Source information**
1. Were seafood tags, invoices, or labels available? ☐ Yes ☐ No ☐ Unknown (If yes, please attach to form)

2. List shippers and associated certification numbers if on tags:

\_\_\_\_\_

3. If harvest areas are known:

Harvest area classification (if known):

Area 1: _____	Date : _____ (MM/DD/YY)	Approved Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____
Area 2: _____	Date : _____ (MM/DD/YY)	Approved Conditionally approved Restricted Prohibited	Product harvested: _____	Harvest State: _____

☐ Check if additional harvest area page is attached

Person completing section 5:

Date completed (MM/DD/YY):

Title/Agency:

Tel:

**Additional harvest area page**

Harvest areas:		Harvest area classification (if known):		
Area 3: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____ Harvest State: _____
Area 4: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____ Harvest State: _____
Area 5: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____ Harvest State: _____
Area 6: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____ Harvest State: _____
Area 7: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____ Harvest State: _____
Area 8: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____ Harvest State: _____
Area 9: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____ Harvest State: _____
Area 10: _____	Date : _____ (MM/DD/YY)	Approved Conditionally restricted Restricted	Conditionally approved Restricted Prohibited	Product harvested: _____ Harvest State: _____

**Additional laboratory results (If more than one specimen is tested, complete one row per specimen)****\*CIDT indicates Culture-Independent Diagnostic Test**

3. <u>Specimen three</u> : Date collected: _____ (MM/DD/YY) Received at public health laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, State lab ID: _____			
Specimen source:	Culture, result:	CIDT, result: Pos Neg Unk Not Done	
Specimen Site:	Pos Neg Unk Not Done	If positive, species identified: _____	
If Other, specify: _____	If positive, species identified: _____	Name/type of diagnostic test used: _____	
	If species identified as multiple or other, specify: _____	If species identified as multiple or other, please specify: _____	
4. <u>Specimen four</u> : Date collected: _____ (MM/DD/YY) Received at public health laboratory? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, State lab ID: _____			
Specimen source:	Culture, result:	CIDT, result: Pos Neg Unk Not Done	
Specimen Site:	Pos Neg Unk Not Done	If positive, species identified: _____	
If Other, specify: _____	If positive, species identified: _____	Name/type of diagnostic test used: _____	
	If species identified as multiple or other, specify: _____	If species identified as multiple or other, please specify: _____	



Department of  
Health

## FoodNet Case Report Form

The FoodNet Case Report Form should be used for **Campylobacter, Cryptosporidium, Cyclospora, Listeria, Shigella, STEC, Vibrio and Yersinia**. Please fill this form out as complete as possible.  
Do not forget to complete the appropriate disease-specific supplemental form.

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_ DOB: \_\_\_\_\_  
PSN1 \_\_\_\_\_ TN01 CAS1 \_\_\_\_\_ TN01 State Lab Accession #: \_\_\_\_\_

### FOR ADMINISTRATIVE USE

FoodNet Case? ☐ Yes ☐ No ☐ Unknown  
Was the case found during an audit?\* ☐ Yes ☐ No ☐ Unknown *\*FoodNet hospital visits constitutes an audit.\**  
Was the case interviewed by public health? ☐ Yes ☐ No ☐ Unknown  
*If no, was an attempt made?* ☐ Yes ☐ No ☐ Unknown  
Interviewer's Name: \_\_\_\_\_  
Was an exposure history obtained? ☐ Yes ☐ No ☐ Unknown  
Date of first attempt: \_\_\_\_\_  
Date of Interview: \_\_\_\_\_

### DEMOGRAPHICS

Reported Age: \_\_\_\_\_ ☐ Days ☐ Months ☐ Years Sex: ☐ Male ☐ Female ☐ Unknown  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Did patient immigrate to the US within 7 days of specimen collection? ☐ Yes ☐ No ☐ Unknown  
In the past 7 days, has the patient lived/stayed overnight in any of the following locations? (check all that apply)  
☐ Dormitory ☐ Long-term Care Facility/Rehabilitation Center ☐ Homeless Shelter ☐ Outdoors/Other structure not intended for housing  
☐ Correctional Facility ☐ Other Communal Living: \_\_\_\_\_ ☐ None of the above ☐ Unknown  
Ethnicity: ☐ Hispanic Race: ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ White  
☐ Not Hispanic ☐ Hawaiian / Pacific Islander ☐ Refused ☐ Other: \_\_\_\_\_  
Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Is this patient associated with a daycare facility? ☐ Yes ☐ No ☐ Unknown  
*If yes, specify association:* ☐ Attend daycare ☐ Work/volunteer at daycare ☐ Live with daycare attendee  
*If yes, name of daycare:* \_\_\_\_\_  
Is this patient a food handler? ☐ Yes ☐ No ☐ Unknown  
*If yes, name of restaurant/facility:* \_\_\_\_\_

### LAB REPORT

Reporting Facility: \_\_\_\_\_ Ordering Facility: \_\_\_\_\_  
Ordering Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Jurisdiction: ☐ East Tennessee ☐ Mid-Cumberland ☐ Northeast ☐ South Central ☐ Southeast  
☐ West Tennessee ☐ Upper Cumberland ☐ Nashville/Davidson ☐ Chattanooga/Hamilton ☐ Knoxville/Knoxville  
☐ Jackson/Madison ☐ Memphis/Shelby ☐ Sullivan ☐ Out of Tennessee ☐ Unassigned  
Specimen Source: ☐ Blood ☐ CSF ☐ Stool  
☐ Urine ☐ Unknown ☐ Other \_\_\_\_\_

Lab Report Date: _____	ORGANISM IDENTIFIED	TEST TYPE(S)	CASE STATUS
Date Received by Public Health: _____	<input type="checkbox"/> Campylobacter <input type="checkbox"/> Cryptosporidium	<input type="checkbox"/> Culture	<input type="checkbox"/> Confirmed
Date Specimen Collected: _____	<input type="checkbox"/> Cyclospora <input type="checkbox"/> Listeria <input type="checkbox"/> Shigella	<input type="checkbox"/> PCR	<input type="checkbox"/> Probable
	<input type="checkbox"/> STEC <input type="checkbox"/> Vibrio <input type="checkbox"/> Yersinia	<input type="checkbox"/> EIA	<input type="checkbox"/> Suspect
		<input type="checkbox"/> Other: _____	

### OUTBREAK/CLUSTER

Is this case part of an outbreak? ☐ Yes ☐ No ☐ Unknown CDC Cluster Code: \_\_\_\_\_  
Type of Outbreak: \_\_\_\_\_ CDC EFORS/NORS Number: \_\_\_\_\_  
☐ Animal Contact ☐ Environmental Contamination Other than Food/Water ☐ Foodborne  
☐ Indeterminate ☐ Person-to-Person ☐ Waterborne  
☐ Other: \_\_\_\_\_

**INVESTIGATION**

Investigation Start Date: \_\_\_\_\_

Investigator: \_\_\_\_\_

Investigation Status: ☐ Open ☐ Closed

Date Assigned to Investigation: \_\_\_\_\_

**SYMPTOM HISTORY**

Date of Illness Onset: \_\_\_\_\_

First Symptom: \_\_\_\_\_

**Symptoms:** ☐ Diarrhea ☐ Bloody Diarrhea ☐ Constipation  
*Check all that apply* ☐ Vomiting ☐ Nausea ☐ Weight Loss  
☐ Fatigue ☐ Chills ☐ Fever (Max Temp: \_\_\_\_\_ °F)  
☐ Headache ☐ Abdominal Cramps ☐ Muscle Aches  
☐ Other: \_\_\_\_\_

*If yes to diarrhea, date of diarrhea onset:* \_\_\_\_\_*If yes to vomiting, date of vomiting onset:* \_\_\_\_\_As of today, are you still experiencing symptoms? ☐ Yes ☐ No ☐ Unknown*If recovered, date of recovery:* \_\_\_\_\_Duration of Illness: \_\_\_\_\_ ☐ Minutes ☐ Hours ☐ Days**CLINICAL INFORMATION/HOSPITALIZATION**

Was the patient hospitalized for this illness?

☐ Yes ☐ No ☐ Unknown*If yes, Hospital Name:* \_\_\_\_\_*Admission Date:* \_\_\_\_\_*Discharge Date:* \_\_\_\_\_Was the patient transferred from one hospital to another?☐ Yes ☐ No ☐ Unknown*If yes, specify the hospital to which the patient was transferred:*

Was there a second hospitalization?

☐ Yes ☐ No ☐ Unknown*If yes, Hospital Name:* \_\_\_\_\_*Admission Date:* \_\_\_\_\_*Discharge Date:* \_\_\_\_\_

During any part of the hospitalization, did the patient stay in and Intensive Care Unit (ICU) or a Critical Care Unit (CCU)?

☐ Yes ☐ No ☐ UnknownIs the patient pregnant? ☐ Yes ☐ No ☐ UnknownDid the patient die from this illness? ☐ Yes ☐ No ☐ Unknown**TRAVEL HISTORY**Did the patient travel prior to the onset of illness? ☐ Yes ☐ No ☐ Unknown

Type	Destination	Date of Arrival	Date of Departure
<input type="checkbox"/> Domestic <input type="checkbox"/> International			
<input type="checkbox"/> Domestic <input type="checkbox"/> International			
<input type="checkbox"/> Domestic <input type="checkbox"/> International			

Notes:

**RELATED CASES**Does the patient know of any similarly ill persons (with diarrhea)? ☐ Yes ☐ No ☐ UnknownAre there any other cases related to this one? ☐ Yes, household ☐ Yes, outbreak ☐ No, sporadic ☐ Unknown*If yes, did the health department collect contact information about other similarly ill persons to investigate further?*☐ Yes ☐ No ☐ Unknown

Provide names, onset dates, contact information and any other details for similarly ill persons or related cases: