State:____ Year: _____

Reset Form

Age: ____ Sex: ____ Last Name: _____

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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State:____ Year: _____ Reset Form Age: ____ Sex: ____ Last Name: _____

CHOLERA AND OTHER VIBRIO ILLNESS SURVEILLANCE REPORT

OMB 0920- 0728

CENTERS FOR DISEASE CONTROL AND PREVENTION

REPORTING HEALTH DEPARTMENT			SEND COMPLETED REPORT TO STATE INFECTION CONTROL
State	City	County/Parish	State will forward to: covisresponse@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
☐☐			

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 *(required)*

5. Race:
- ☐ American Indian/Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other
- ☐ 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. alginolyticus—ALG
V. cholerae O1—CH1
V. cholerae O139—CH3
V. cholerae non-O1, non-O139—CHN
V. cincinnatiensis —CIN
Photobacterium damselae subsp. *Damselae* —DAM
V. fluvialis—FLU
V. furnissii—FUR
Grimontia hollisae—HOL
V. metschnikovii—MET
V. mimicus—MIM
V. parahaemolyticus—PAR
V. vulnificus—VUL
Vibrio—species not identified—NID
Other—OTH (Specify below)
Multiple species—MUL (Specify below)
☐ Epidemiologically linked to a laboratory detected case (no lab results)

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. Specimen one: Date collected: _____ (MM/DD/YY) Received at public health laboratory? ☐ Yes ☐ No ☐ Unk If yes, State lab ID: _____

Specimen source: ▼
Specimen Site: ▼
If Other, specify: _____

Culture, result: ☐ Pos ☐ Neg ☐ Unk ☐ Not Done
If positive, species identified: _____ ▼
If species identified as multiple or other, specify: _____

CIDT, result: ☐ Pos ☐ Neg ☐ Unk ☐ Not Done
If positive, species identified: _____ ▼
Name/type of diagnostic test used: _____
If species identified as mulitple or other, please specify: _____

2. Specimen two: Date collected: _____ (MM/DD/YY) Received at public health laboratory? ☐ Yes ☐ No ☐ Unk If yes, State lab ID: _____

Specimen Source: ▼
Specimen Site: ▼
If Other, specify: _____

Culture, result: ☐ Pos ☐ Neg ☐ Unk ☐ Not Done
If positive, species identified: _____ ▼
If species identified as multiple or other, specify: _____

CIDT, result: ☐ Pos ☐ Neg ☐ Unk ☐ Not Done
If positive, species identified: _____ ▼
Name/type of diagnostic test used: _____
If species identified as mulitple 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. Serotype: ☐ Inaba ☐ Ogawa ☐ Hikojima ☐ Not done ☐ Unk

5. BioType: ☐ El Tor ☐ Classical ☐ Not done ☐ Unk

6. Toxigenic: ☐ Yes ☐ No ☐ Not done ☐ Unk

3. CLINICAL INFORMATION

1. Date illness began (MM/DD/YY): _____

2. Duration of illness (Days): _____

3a. Did patient die? ☐ Yes ☐ No ☐ Unknown

3b. If yes, date (MM/DD/YY): _____

4a. Admitted to a hospital overnight for this illness?

☐ Yes ☐ No ☐ Unknown

4b. If yes, admission date (MM/DD/YY): _____

4c. Discharge date (MM/DD/YY): _____

5. Did patient take an antibiotic as treatment for this illness? ☐ Yes ☐ No ☐ Unknown

If yes, name(s) of antibiotic(s):	Date began antibiotic (MM/DD/YY):	Date ended antibiotic: (MM/DD/YY):
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Signs and symptoms:	Yes	No	Unk
Vomiting	☐	☐	☐
Diarrhea	☐	☐	☐
Visible blood in stools	☐	☐	☐
Abdominal cramps	☐	☐	☐
Fever (>100.4F or 38 C)	☐	☐	☐
Muscle pain	☐	☐	☐
Septic shock	☐	☐	☐
Cellulitis (Site_____)	☐	☐	☐
Bullae (Site_____)	☐	☐	☐
Sequelae (e.g. amputation, skin graft) (Type:_____)	☐	☐	☐
Other (ear pain, discharge, rash, etc.): _____	☐	☐	☐

Medical history (optional for probable cases):	Yes	No	Unk
Alcoholism	☐	☐	☐
Diabetes	☐	☐	☐
Gastric surgery	☐	☐	☐
Heart disease (If yes, Heart failure? ☐Y ☐N ☐U)	☐	☐	☐
Hematologic disease	☐	☐	☐
Immunosuppressive condition/immunodeficiency	☐	☐	☐
Immunosuppressive therapy	☐	☐	☐
Liver disease	☐	☐	☐
Cancer	☐	☐	☐
Kidney disease	☐	☐	☐
Took antacids or ulcer medication in past 30 days (Type/Frequency:_____)	☐	☐	☐
Peptic ulcer	☐	☐	☐
Other: _____	☐	☐	☐

Additional signs and symptoms comments:

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? ☐ Yes ☐ No ☐ Unk

5. Did patient travel to another country in the 7 days before illness onset? ☐ Yes ☐ No ☐ 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? Y N U	Eaten raw? Y N U	Multiple dates? Y N U	Last date consumed (MM/ DD/ YY)	Type of Seafood	Eaten? Y N U	Eaten raw? Y N U	Multiple dates? Y N U	Last date consumed (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:

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 ☐ Unknown

6. 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 ☐ Conditionally restricted ☐ Restricted ☐ Prohibited	Product harvested: _____	Harvest State: _____
Area 2: _____	Date : _____ (MM/DD/YY)	☐ Approved ☐ Conditionally approved ☐ Conditionally restricted ☐ 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 approved ☐ Conditionally restricted ☐ Restricted ☐ Prohibited	Product harvested: _____	Harvest State: _____
Area 4: _____	Date : _____ (MM/DD/YY)	☐ Approved ☐ Conditionally approved ☐ Conditionally restricted ☐ Restricted ☐ Prohibited	Product harvested: _____	Harvest State: _____
Area 5: _____	Date : _____ (MM/DD/YY)	☐ Approved ☐ Conditionally approved ☐ Conditionally restricted ☐ Restricted ☐ Prohibited	Product harvested: _____	Harvest State: _____
Area 6: _____	Date : _____ (MM/DD/YY)	☐ Approved ☐ Conditionally approved ☐ Conditionally restricted ☐ Restricted ☐ Prohibited	Product harvested: _____	Harvest State: _____
Area 7: _____	Date : _____ (MM/DD/YY)	☐ Approved ☐ Conditionally approved ☐ Conditionally restricted ☐ Restricted ☐ Prohibited	Product harvested: _____	Harvest State: _____
Area 8: _____	Date : _____ (MM/DD/YY)	☐ Approved ☐ Conditionally approved ☐ Conditionally restricted ☐ Restricted ☐ Prohibited	Product harvested: _____	Harvest State: _____
Area 9: _____	Date : _____ (MM/DD/YY)	☐ Approved ☐ Conditionally approved ☐ Conditionally restricted ☐ Restricted ☐ Prohibited	Product harvested: _____	Harvest State: _____
Area 10: _____	Date : _____ (MM/DD/YY)	☐ Approved ☐ Conditionally approved ☐ Conditionally restricted ☐ 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. Specimen three: Date collected: _____ (MM/DD/YY) Received at public health laboratory? ☐ Yes ☐ No ☐ Unk If yes, State lab ID:_____

Specimen source:

Specimen Site:

If Other, specify: _____

Culture, result:

☐ Pos ☐ Neg ☐ Unk ☐ Not Done

If positive, species identified: _____

If species identified as multiple or other, specify: _____

CIDT, result: ☐ Pos ☐ Neg ☐ Unk ☐ Not Done

If positive, species identified: _____

Name/type of diagnostic test used: _____

If species identified as multiple or other, please specify: _____

4. Specimen four: Date collected: _____ (MM/DD/YY) Received at public health laboratory? ☐ Yes ☐ No ☐ Unk If yes, State lab ID:_____

Specimen source:

Specimen Site:

If Other, specify: _____

Culture, result:

☐ Pos ☐ Neg ☐ Unk ☐ Not Done

If positive, species identified: _____

If species identified as multiple or other, specify: _____

CIDT, result: ☐ Pos ☐ Neg ☐ Unk ☐ Not Done

If positive, species identified: _____

Name/type of diagnostic test used: _____

If species identified as multiple or other, please specify: _____

Save Form Print Form Email Form