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.): _____	☐	☐	☐

Additional signs and symptoms comments:

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: _____	☐	☐	☐

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

FoodNet Case Report Form

Department of Health

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 no forget to complete the appropriate disease-specific supplemental form.

Clear Print

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 **Date of first attempt:** _____

If no, was an attempt made? ☐ Yes ☐ No ☐ Unknown **Date of Interview:** _____

Interviewer's Name: _____

Was an exposure history obtained? ☐ Yes ☐ No ☐ Unknown

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 ☐ Not Hispanic **Race:** ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ White ☐ 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 ☐ Knox/Knoxville ☐ Jackson/Madison ☐ Memphis/Shelby ☐ Sullivan ☐ Out of Tennessee ☐ Unassigned

Specimen Source: ☐ Blood ☐ CSF ☐ Stool ☐ Urine ☐ Unknown ☐ Other _____

Lab Report Date: _____

Date Received by Public Health: _____

Date Specimen Collected: _____

Organism Identified

☐ Campylobacter ☐ Cryptosporidium ☐ Cyclospora ☐ Listeria ☐ Shigella ☐ STEC ☐ Vibrio ☐ Yersinia

Test Type(s)

☐ Culture ☐ PCR ☐ EIA ☐ Other:

Case Status

☐ Confirmed ☐ Probable ☐ Suspect

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: _____

Clear Print

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 ☐ Unknown

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

Did 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
☐ Domestic ☐ International			
☐ Domestic ☐ International			
☐ Domestic ☐ International			

Notes:

RELATED CASES

Does the patient know of any similarly ill persons (with diarrhea)? ☐ Yes ☐ No ☐ Unknown

Are 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: