

California Department of Public Health
 Center for Infectious Diseases
 Division of Communicable Disease Control
 Infectious Diseases Branch
 Surveillance and Statistics Section
 MS 7306, P.O. Box 997377
 Sacramento, CA 95899-7377

CHOLERA AND OTHER *VIBRIO* ILLNESS CASE REPORT

Check one: Cholera Non-cholera *Vibrio* illness

PATIENT INFORMATION					
<i>Last Name</i>	<i>First Name</i>	<i>Middle Name</i>	<i>Suffix</i>	<i>Primary Language</i>	
<i>Social Security Number (9 digits)</i>		<i>DOB (mm/dd/yyyy)</i>	<i>Age</i>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
<i>Address Number & Street – Residence</i>			<i>Apartment / Unit Number</i>		<i>Ethnicity (check one)</i>
<i>City / Town</i>		<i>State</i>	<i>Zip Code</i>		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown
<i>Census Tract</i>	<i>County of Residence</i>		<i>Country of Residence</i>		<i>Race(s)</i>
<i>Country of Birth</i>		<i>If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)</i>			(check all that apply, race descriptions on page 10) The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.
<i>Home Telephone</i>		<i>Cellular Phone / Pager</i>		<i>Work / School Telephone</i>	
<i>E-mail Address</i>			<i>Other Electronic Contact Information</i>		
<i>Work / School Location</i>			<i>Work / School Contact</i>		
<i>Gender</i>					
<input type="checkbox"/> Female <input type="checkbox"/> Trans female / transwoman <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Trans male/ transman <input type="checkbox"/> Identity not listed <input type="checkbox"/> Declined to answer					
<i>Pregnant?</i>			<i>If Yes, Est. Delivery Date (mm/dd/yyyy)</i>		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
<i>Medical Record Number</i>			<i>Patient's Parent/Guardian Name</i>		
<i>Occupation Setting (see list on page 11)</i>			<i>Other Describe/Specify</i>		
<i>Occupation (see list on page 11)</i>			<i>Other Describe/Specify</i>		
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian (check all that apply, see list on page 10) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Korean <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Laotian <input type="checkbox"/> Cambodian <input type="checkbox"/> Malaysian <input type="checkbox"/> Chinese <input type="checkbox"/> Pakistani <input type="checkbox"/> Filipino <input type="checkbox"/> Sri Lankan <input type="checkbox"/> Hmong <input type="checkbox"/> Taiwanese <input type="checkbox"/> Indonesian <input type="checkbox"/> Thai <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other: _____ <input type="checkbox"/> Black or African-American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander (check all that apply, see list on page 10) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Fijian <input type="checkbox"/> Tongan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other: _____ <input type="checkbox"/> White <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown					
ADDITIONAL PATIENT DEMOGRAPHICS					
<i>Sex Assigned at Birth</i>		<i>Sexual Orientation</i>			
<input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Male <input type="checkbox"/> Declined to answer		<input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Questioning, unsure, or patient doesn't know <input type="checkbox"/> Declined to answer <input type="checkbox"/> Gay, lesbian, or same-gender loving <input type="checkbox"/> Orientation not listed <input type="checkbox"/> Unknown <input type="checkbox"/> Bisexual			
CLINICAL INFORMATION					
<i>Physician Name - Last Name</i>			<i>First Name</i>		<i>Telephone Number</i>

First three letters of patient's last name:

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SIGNS AND SYMPTOMS				
Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset Date (mm/dd/yyyy)	Onset Time (hh:mm)	Specify AM/PM <input type="checkbox"/> AM <input type="checkbox"/> PM	Duration of Illness (days)
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Fever (>100.4°F or 38°C)				<i>Highest Temperature (specify °F / °C)</i>
Vomiting				
Diarrhea				<i>Max. Number of Stools in 24-hr Period</i>
Bloody diarrhea				
Abdominal cramps				
Muscle pain				
Cellulitis				<i>Location</i>
Bullae				<i>Location</i>
Septic shock				
Ear pain or discharge				
Sequelae (e.g., amputation, skin graft)				<i>Type</i>
<i>Other (specify)</i>				
PAST MEDICAL HISTORY				
History	Yes	No	Unk	If Yes, Specify as Noted
Ever received a cholera vaccine				<i>Most Recent Vaccination Date (mm/dd/yyyy)</i>
Underlying Medical Conditions				
Diabetes				<i>On insulin?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Peptic ulcer				
Gastric surgery				<i>Type</i>
Heart disease				<i>Heart failure?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Liver disease				<i>Type</i>
Cancer (Malignancy)				<i>Type</i>
Kidney disease				<i>Type</i>
Hematologic disease				<i>Type</i>
Immunodeficiency disorder				<i>Type (Please do NOT disclose or specify HIV/AIDS information on this form.)</i>
Drink alcohol				<i>How many servings of alcohol in a typical week?</i>
<i>Other (specify)</i>				

First three letters of patient's last name:

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RECENT TREATMENT HISTORY (in the 30 days PRIOR to the illness onset date)

Treatment	Yes	No	Unk	If Yes, Specify as Noted
Antibiotics				<i>Treatment Name</i> <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Azithromycin <input type="checkbox"/> Cephalexin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Other (specify): _____
Chemotherapy				
Radiotherapy				
Systemic steroids				
Immunosuppressants				
Antacids (e.g., Mylanta, Tums, Rolaids)				<i>Treatment Name</i> <i>Frequency</i>
H2 blocker or other ulcer medications (e.g., Pepcid, Prilosec, Tagamet)				<i>Treatment Name</i> <i>Frequency</i>

HOSPITALIZATION

Did patient visit the emergency room for illness?
 Yes No Unknown

Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If Yes, how many total hospital nights?	During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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If there were any ER or hospital stays related to this illness, specify details in the Hospitalization – Details section below.

HOSPITALIZATION – DETAILS

<i>Hospital Name 1</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>
<i>Hospital Name 2</i>	<i>Street Address</i>			<i>Admit Date (mm/dd/yyyy)</i>	
	<i>City</i>			<i>Discharge / Transfer Date (mm/dd/yyyy)</i>	
	<i>State</i>	<i>Zip Code</i>	<i>Telephone Number</i>	<i>Medical Record Number</i>	<i>Discharge Diagnosis</i>

TREATMENT / MANAGEMENT

Received treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify the treatments below.
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TREATMENT / MANAGEMENT – DETAILS

<i>Treatment Type 1</i> <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	<i>Treatment Name</i> <input type="checkbox"/> Azithromycin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Levaquin <input type="checkbox"/> Other (specify): _____	<i>Date Started (mm/dd/yyyy)</i>	<i>Date Ended (mm/dd/yyyy)</i>
<i>Treatment Type 2</i> <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	<i>Treatment Name</i> <input type="checkbox"/> Azithromycin <input type="checkbox"/> Ciprofloxacin <input type="checkbox"/> Doxycycline <input type="checkbox"/> Levaquin <input type="checkbox"/> Other (specify): _____	<i>Date Started (mm/dd/yyyy)</i>	<i>Date Ended (mm/dd/yyyy)</i>

OUTCOME

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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First three letters of patient's last name:

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LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

<i>Collection Date (mm/dd/yyyy)</i>	<i>Specimen Type (e.g., stool, wound)</i> <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Ear discharge/drainage <input type="checkbox"/> Urine <input type="checkbox"/> Wound <input type="checkbox"/> Other: _____	<i>Specimen Source Site/Anatomical Source of the Specimen (e.g., blister, right eye, left ear, right ankle)</i>
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<i>Vibrio Culture Result</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Not Done	<i>If culture completed, Vibrio species identified</i> <input type="checkbox"/> <i>V. albensis</i> <input type="checkbox"/> <i>V. cholerae</i> non-O1, non-O139 <input type="checkbox"/> <i>V. furnissii</i> <input type="checkbox"/> <i>V. vulnificus</i> <input type="checkbox"/> <i>V. alginolyticus</i> <input type="checkbox"/> <i>V. cholerae</i> , serogroup not specified <input type="checkbox"/> <i>V. metschnikovii</i> <input type="checkbox"/> <i>Grimontia hollisae</i> <input type="checkbox"/> <i>V. cholerae</i> O1 <input type="checkbox"/> <i>V. cincinnatiensis</i> <input type="checkbox"/> <i>V. mimicus</i> <input type="checkbox"/> <i>Photobacterium damsela</i> <input type="checkbox"/> <i>V. cholerae</i> O139 <input type="checkbox"/> <i>V. fluvialis</i> <input type="checkbox"/> <i>V. parahaemolyticus</i> <input type="checkbox"/> <i>Vibrio species - not identified</i> <input type="checkbox"/> Other (specify): _____
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<i>Vibrio Culture-Independent Diagnostic Test (CIDT: e.g., PCR) Result</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Not Done	<i>If CIDT, type of diagnostic test</i> <input type="checkbox"/> PCR <input type="checkbox"/> Antigen-based <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown	<i>If CIDT, name of diagnostic test</i> <input type="checkbox"/> Biofire FilmArray <input type="checkbox"/> Diatherix <input type="checkbox"/> Luminex <input type="checkbox"/> Nanosphere <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown	<i>If CIDT completed, Vibrio species identified</i> <input type="checkbox"/> <i>Vibrio</i> <input type="checkbox"/> <i>Vibrio cholerae</i> , serogroup not specified <input type="checkbox"/> <i>Vibrio & V. cholerae</i> <input type="checkbox"/> <i>V. parahaemolyticus</i> <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Species not identified
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If Vibrio cholerae O1 or O139, specify serotype, biotype, and whether toxigenic.

<i>Serotype</i> <input type="checkbox"/> Inaba <input type="checkbox"/> Ogawa <input type="checkbox"/> Hikojima <input type="checkbox"/> Not done <input type="checkbox"/> Unk	<i>Biotype</i> <input type="checkbox"/> El Tor <input type="checkbox"/> Classical <input type="checkbox"/> Not done <input type="checkbox"/> Unk
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<i>Toxigenic</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, toxin positive by:</i> <input type="checkbox"/> ELISA <input type="checkbox"/> Latex agglutination <input type="checkbox"/> PCR <input type="checkbox"/> Other (specify): _____
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<i>Were other non-Vibrio organisms isolated from the same specimen?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, specify organism(s)</i>
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<i>Clinical Laboratory Name</i>	<i>Clinical Laboratory Telephone</i>
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PUBLIC HEALTH LABORATORY TESTING

<i>Was isolate tested at a local public health lab?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Local Public Health Laboratory Name</i>	<i>Local Laboratory Isolate ID Number</i>
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<i>Was isolate tested at a state public health lab?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>State Public Health Laboratory Name</i>	<i>State Laboratory Isolate ID Number</i>
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<i>Was whole genome sequencing (WGS) completed?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>WGS ID Number</i>	<i>Specify results (e.g., allele code) or attach</i>
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ANTIMICROBIAL SUSCEPTIBILITY TESTING

<i>Antimicrobial susceptibility testing completed?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Ampicillin: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done
<i>Attach additional results or upload to the CalREDIE electronic filing cabinet.</i>	Azithromycin: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done
	Cefoxitin: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done
	Ciprofloxacin: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done
	Tetracycline: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done
	Trimethoprim-sulfamethoxazole: <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done
	Other, specify: _____ <input type="checkbox"/> Susceptible <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant <input type="checkbox"/> Not done

First three letters of patient's last name:

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EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: UP TO 7 DAYS PRIOR TO ILLNESS ONSET

TRAVEL HISTORY

Did patient travel **outside county of residence** during the incubation period?

Yes No Unk

If Yes, specify all locations and dates below.

TRAVEL HISTORY - DETAILS

Travel Type	Location			Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
	State	Country	Other Location Details (city, resort, etc.)		
<input type="checkbox"/> Domestic <input type="checkbox"/> Unk <input type="checkbox"/> International					
<input type="checkbox"/> Domestic <input type="checkbox"/> Unk <input type="checkbox"/> International					
<input type="checkbox"/> Domestic <input type="checkbox"/> Unk <input type="checkbox"/> International					

TRAVEL HISTORY - REASON FOR TRAVEL (CHOLERA CASES ONLY)

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

Visiting relatives/friends Tourism Medical/disaster relief Other: _____
 Business Active duty military Unk

FOOD HISTORY

DID THE PATIENT EAT ANY OF THE FOLLOWING TYPES OF SEAFOOD DURING THE INCUBATION PERIOD?

(IF EATEN MULTIPLE TIMES, USE MOST RECENT MEAL.)

Food Item	Yes	No	Unk	If Yes, Specify as Noted					
Oysters				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date Last Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM) __ : __ <input type="checkbox"/> AM <input type="checkbox"/> PM			
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Amount Consumed			
				Location Purchased (restaurant/store name and address)					
				Location Consumed (restaurant/store name and address)					
				Were the oysters part of a dish, like chef special, happy hour special, shooters, etc.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				If Yes, specify type of dish	
				Did any dining partners consume the same seafood? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				If Yes, did any become ill? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
				Type of Oysters <input type="checkbox"/> Atlantic <input type="checkbox"/> Blue Point <input type="checkbox"/> Carlsbad <input type="checkbox"/> Church Point <input type="checkbox"/> Kumamoto <input type="checkbox"/> Pacific <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unk				If Unknown, please provide any other details you can remember (Pacific NW, East Coast, Canada, etc.)	
Clams				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date Last Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM) __ : __ <input type="checkbox"/> AM <input type="checkbox"/> PM			
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Amount Consumed			
				Location Purchased (restaurant/store name and address)					
				Location Consumed (restaurant/store name and address)					

First three letters of patient's last name:

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Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Crab				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date Last Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM) __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Amount Consumed
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Lobster				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date Last Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM) __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Amount Consumed
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Mussels				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date Last Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM) __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Amount Consumed
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Shrimp				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date Last Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM) __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Amount Consumed
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Crawfish				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date Last Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM) __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Amount Consumed
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Scallops				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date Last Eaten (mm/dd/yyyy)	Time Eaten (HH:MM AM/PM) __:__:__ <input type="checkbox"/> AM <input type="checkbox"/> PM
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Amount Consumed
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		

First three letters of patient's last name:

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Food Item	Yes	No	Unk	If Yes, Specify as Noted
Other shellfish (specify): _____				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				Date Last Eaten (mm/dd/yyyy)
				Time Eaten (HH:MM AM/PM) __ : __ <input type="checkbox"/> AM <input type="checkbox"/> PM
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				Amount Consumed
				Location Purchased (restaurant/store name and address)
				Location Consumed (restaurant/store name and address)

Food Item	Yes	No	Unk	If Yes, Specify as Noted
Fish (specify): _____				Consumed on multiple dates? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				Date Last Eaten (mm/dd/yyyy)
				Time Eaten (HH:MM AM/PM) __ : __ <input type="checkbox"/> AM <input type="checkbox"/> PM
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				Eaten undercooked? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				Amount Consumed
				Location Purchased (restaurant/store name and address)
				Location Consumed (restaurant/store name and address)

SEAFOOD EXPOSURE / ENVIRONMENTAL HEALTH INVESTIGATION

If seafood is suspected as the source of infection, local environmental health should investigate the source of the seafood and obtain available shellfish tags if oysters or other shellfish were consumed.

What is the status of the Environmental Health investigation? <input type="checkbox"/> Completed <input type="checkbox"/> In progress <input type="checkbox"/> Not conducted	Is the Seafood Investigation Report Form attached to this report? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
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If patient consumed oysters, clams, mussels, or scallops, are the shellfish tags attached to this report?
 Yes No Not Applicable Unk

EXPOSURES / RISK FACTORS – OTHER (IF EXPOSURE OCCURRED MULTIPLE TIMES, USE MOST RECENT DATE)

DID THE PATIENT HAVE CONTACT WITH ANY OF THE FOLLOWING DURING THE INCUBATION PERIOD?

EXPOSURE/RISK	Yes	No	Unk	If Yes, Specify as Noted
Body of water				Water type <input type="checkbox"/> Salt water <input type="checkbox"/> Brackish water <input type="checkbox"/> Unk <input type="checkbox"/> Fresh water <input type="checkbox"/> Other: _____
				Date of Exposure (mm/dd/yyyy)
				Name and Location of Water
				Describe exposure (e.g., swimming, surfing, etc.)
Drippings from raw or live seafood, including handling/cleaning				Type of Seafood
				Date of Exposure (mm/dd/yyyy)
				Describe Exposure (e.g., handling or cleaning)
Other contact with marine or freshwater life, including stings/bites				Type of Marine or Freshwater Life
				Date of Exposure (mm/dd/yyyy)
				Describe Exposure (e.g., stings or bites)
Pre-existing wound at site of exposure				Describe how wound occurred and anatomic site of pre-existing wound
New wound sustained at site of exposure				Describe how wound occurred and anatomic site of new wound
Other Exposures of Interest (describe)				
If yes to any of the above skin exposures, was this an occupational exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				

First three letters of patient's last name:

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ILL CONTACTS

Any contacts with similar illness (including household contacts)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify details below.
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ILL CONTACTS – DETAILS

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Name 2	Age	Gender	Telephone Number	Type of Contact / Relationship	Date of Contact (mm/dd/yyyy)
	Street Address			Exposure Event	Illness Onset Date (mm/dd/yyyy)
	City	State	Zip Code	Occupation	Sensitive occupation / situation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	Local Health Jurisdiction	Telephone Number	Date Reported (mm/dd/yyyy)
First Reported By <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____	Health education provided? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Restriction / clearance needed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Contact Name / Case Number
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DISEASE CASE CLASSIFICATION

Case Classification (see case definition on page 9)
 Confirmed Probable Not a case

OUTBREAK

Part of known outbreak? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, extent of outbreak: <input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
Mode of Transmission <input type="checkbox"/> Point source <input type="checkbox"/> Person-to-person <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	Vehicle of Outbreak		
Pattern 1 ID Number	Pattern 2 ID Number	CDC PulseNet Cluster Code	NORS ID

STATE USE ONLY

State Case Classification
 Confirmed Probable Not a case Need additional information

CASE DEFINITION**CHOLERA (Toxigenic *Vibrio cholerae* O1 or O139) (2010)****CLINICAL DESCRIPTION**

An illness characterized by diarrhea and / or vomiting; severity is variable.

LABORATORY CRITERIA FOR DIAGNOSIS

- Isolation of **toxigenic** (i.e., cholera toxin-producing) *Vibrio cholerae* O1 or O139 from stool or vomitus, OR
- Serologic evidence of recent infection

CASE CLASSIFICATION**Confirmed**

A clinically compatible illness that is laboratory confirmed.

COMMENT

Illnesses caused by strains of *V. cholerae* other than **toxigenic** *V. cholerae* O1 or O139 should not be reported as cases of cholera. The etiologic agent of a case of cholera should be reported as either *V. cholerae* O1 or *V. cholerae* O139.

VIBRIOSIS (2017)**CLINICAL CRITERIA**

An infection of variable severity characterized by watery diarrhea, primary septicemia, or wound infection. Asymptomatic infections may occur, and the organism may cause extra-intestinal infection.

LABORATORY CRITERIA FOR DIAGNOSIS**Confirmatory laboratory evidence**

Isolation of a species of the family *Vibrionaceae* (other than toxigenic *Vibrio cholerae* O1 or O139, which are reportable as cholera) from a clinical specimen.

Supportive laboratory evidence

Detection of a species of the family *Vibrionaceae* (other than toxigenic *Vibrio cholerae* O1 or O139, which are reportable as cholera) from a clinical specimen using a culture-independent diagnostic test.

EPIDEMIOLOGIC LINKAGE

A clinically compatible case that is epidemiologically linked to a case that meets the supportive or confirmatory laboratory criteria for diagnosis.

CRITERIA TO DISTINGUISH A NEW CASE FROM AN EXISTING CASE

- A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual.
- When two or more different species of the family *Vibrionaceae* are identified in one or more specimens from the same individual, each should be reported as a separate case.

CASE CLASSIFICATION**Confirmed**

A case that meets the confirmed laboratory criteria for diagnosis.

Probable

A case that meets the supportive laboratory criteria for diagnosis, or a clinically compatible case that is epidemiologically linked to a case that meets the supportive or confirmatory laboratory criteria for diagnosis.

RACE DESCRIPTIONS	
Race	Description
American Indian or Alaska Native	Patient has origins in any of the original peoples of North and South America (including Central America).
Asian	Patient has origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in any of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in any of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in any of the original peoples of Europe, the Middle East, or North Africa.
ASIAN GROUPS	
<ul style="list-style-type: none"> • Bangladeshi • Bhutanese • Burmese • Cambodian • Chinese 	<ul style="list-style-type: none"> • Filipino • Hmong • Indian • Indonesian • Iwo Jiman
<ul style="list-style-type: none"> • Japanese • Korean • Laotian • Madagascar • Malaysian 	<ul style="list-style-type: none"> • Maldivian • Nepalese • Okinawan • Pakistani • Singaporean
<ul style="list-style-type: none"> • Sri Lankan • Taiwanese • Thai • Vietnamese 	
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS	
<ul style="list-style-type: none"> • Carolinian • Chamorro • Chuukese • Fijian • Guamanian 	<ul style="list-style-type: none"> • Kiribati • Kosraean • Mariana Islander • Marshallese • Melanesian
<ul style="list-style-type: none"> • Micronesian • Native Hawaiian • New Hebrides • Palauan • Papua New Guinean 	<ul style="list-style-type: none"> • Pohnpeian • Polynesian • Saipanese • Samoan • Solomon Islander
<ul style="list-style-type: none"> • Tahitian • Tokelauan • Tongan • Yapese 	

OCCUPATION SETTING

- | | |
|--|--|
| <ul style="list-style-type: none"> • Childcare / Preschool • Correctional Facility • Drug Treatment Center • Food Service • Health Care - Acute Care Facility • Health Care - Long Term Care Facility • Health Care - Other | <ul style="list-style-type: none"> • Homeless Shelter • Laboratory • Military Facility • Other Residential Facility • Place of Worship • School • Other |
|--|--|

OCCUPATION

- | | |
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| <ul style="list-style-type: none"> • Adult film actor / actress • Agriculture - farmworker or laborer (crop, nursery, or greenhouse) • Agriculture - field worker • Agriculture - migratory / seasonal worker • Agriculture - other / unknown • Animal - animal control worker • Animal - farm worker or laborer (farm or ranch animals) • Animal - veterinarian or other animal health practitioner • Animal - other / unknown • Clerical, office, or sales worker • Correctional facility - employee • Correctional facility - inmate • Craftsman, foreman, or operative • Daycare or child care attendee • Daycare or child care worker • Dentist or other dental health worker • Drug dealer • Fire fighting or prevention worker • Flight attendant • Food service - cook or food preparation worker • Food service - host or hostess • Food service - server • Food service - other / unknown • Homemaker • Laboratory technologist or technician • Laborer - private household or unskilled worker • Manager, official, or proprietor • Manicurist or pedicurist • Medical - emergency medical technician or paramedic • Medical - health care worker | <ul style="list-style-type: none"> • Medical - medical assistant • Medical - pharmacist • Medical - physician assistant or nurse practitioner • Medical - physician or surgeon • Medical - nurse • Medical - other / unknown • Military • Police officer • Professional, technical, or related profession • Retired • Sex worker • Stay at home parent / guardian • Student - preschool or kindergarten • Student - elementary or middle school • Student - high school • Student - college or university • Student - other / unknown • Teacher / employee - preschool or kindergarten • Teacher / employee - elementary or middle school • Teacher / employee - high school • Teacher / instructor / employee - college or university • Teacher / instructor / employee - other / unknown • Unemployed - seeking employment • Unemployed - not seeking employment • Unemployed - other / unknown • Volunteer • Other • Refused • Unknown |
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