State of California—Health and Human Services Agency

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

Local ID Number _____

(*Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)*

Report Status (check one)

☐ Preliminary ☐ Final

CHOLERA AND OTHER *VIBRIO* ILLNESS CASE REPORT

Check one: ☐ Cholera

☐ Non-cholera *Vibrio* illness

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	
			☐ Years ☐ Months ☐ Days

Address Number & Street - Residence	*Apartment / Unit Number*

City / Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone / Pager*	*Work / School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work / School Location	*Work / School Contact*

Gender
☐ Male ☐ Female ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent / Guardian Name*

Occupation Setting (see list on page 8)	*Other (Describe / Specify)*

Occupation (see list on page 8)	*Other (Describe / Specify)*

Primary Language
☐ English
☐ Spanish
☐ Other:_____

Ethnicity (check one)
☐ Hispanic / Latino
☐ Non-Hispanic / Non-Latino
☐ Unk

*Race**
(check all that apply, race descriptions on page 8)
☐ African-American / Black
☐ American Indian or Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Thai
- ☐ Vietnamese
- ☐ Other:_____

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Guamanian
- ☐ Other:_____

☐ White
☐ Other:_____
☐ Unk

*Comment: self-identity or self-reporting
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.

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

First three letters of patient's last name: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unk	*Onset Date (mm/dd/yyyy)*	*Date First Sought Medical Care (mm/dd/yyyy)*

Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Fever				*Highest temperature (specify °F / °C)*
Chills				
Vomiting				
Diarrhea				*Max. number of stools in 24-hr period*
Bloody stools				
Muscle pain				
Cellulitis				*Location*
Bullae				*Location*
Shock (systolic BP < 90)				

Other (specify)

PAST MEDICAL HISTORY

History	Yes	No	Unk	If Yes, Specify as Noted
Alcoholism				
Diabetes				*On insulin?* ☐ Yes ☐ No ☐ Unk
Peptic ulcer				
Gastric surgery				*Type*
Heart disease				*Heart failure?* ☐ Yes ☐ No ☐ Unk
Liver disease				*Type*
Malignancy				*Type*
Renal disease				*Type*
Hematologic disease				*Type*
Immunodeficiency				*Type*

Other (specify)

First three letters of patient's last name: | | | |

RECENT TREATMENT HISTORY

Treatment	Yes	No	Unk	If Yes, Specify as Noted: Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Antibiotics	☐	☐	☐			
Chemotherapy	☐	☐	☐			
Radiotherapy	☐	☐	☐			
Systemic steroids	☐	☐	☐			
Immunosuppressants	☐	☐	☐			
Antacids	☐	☐	☐			
H2 blocker or other ulcer medications (e.g., cimetidine, omeprazole)	☐	☐	☐			

HOSPITALIZATION

Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unk	*Was patient hospitalized?* ☐ Yes ☐ No ☐ Unk	*If Yes, how many total hospital nights?*

If there were any ER or hospital stays related to this illness, specify details below.

HOSPITALIZATION - DETAILS

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

TREATMENT / MANAGEMENT

Received treatment? ☐ Yes ☐ No ☐ Unk	*If Yes, specify the treatments below.*

TREATMENT / MANAGEMENT DETAILS

Treatment Type 1 ☐ Antibiotic ☐ Other	*Treatment Name*	*Date Started (mm/dd/yyyy)*	*Date Ended (mm/dd/yyyy)*
Treatment Type 2 ☐ Antibiotic ☐ Other	*Treatment Name*	*Date Started (mm/dd/yyyy)*	*Date Ended (mm/dd/yyyy)*

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ Unk	*If Survived,* Survived as of _____(mm/dd/yyyy)	*Date of Death (mm/dd/yyyy)*

First three letters of patient's last name: | | | |

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Specimen Type (e.g., stool, wound)	*If wound, specify site*	*Type of Test (method)* ☐ PCR ☐ Culture ☐ Other (specify):_____

Vibrio Species isolated

☐ *V. alginolyticus* ☐ *V. cholerae* non-O1, non-O139 ☐ *V. fluvialis* ☐ *V. metschnikovii* ☐ *V. parahaemolyticus*
☐ *V. cholerae* O1 ☐ *V. cincinnatiensis* ☐ *V. furnissii* ☐ *V. mimicus* ☐ *V. vulnificus*
☐ *V. cholerae* O139 ☐ *V. damsela* ☐ *V. (Grimontia) hollisae* ☐ *Vibrio* species - not identified

Collection Date (mm/dd/yyyy)

If Vibrio cholerae O1 or O139, specify serotype, biotype, and whether toxigenic.

Serotype ☐ Inaba ☐ Ogawa ☐ Hikojima ☐ Not done ☐ Unk	*Biotype* ☐ El Tor ☐ Classical ☐ Not done ☐ Unk
Toxigenic ☐ Yes ☐ No ☐ Unk	*If Yes, toxin positive by:* ☐ ELISA ☐ Latex agglutination ☐ PCR ☐ Other (specify):_____
Were other organisms isolated from the same specimen that yielded Vibrio? ☐ Yes ☐ No ☐ Unk	*If Yes, specify organism(s)*
Was molecular fingerprinting (e.g., PFGE) done? ☐ Yes ☐ No ☐ Unk	*If Yes, isolate pattern*
Laboratory Name	*Telephone*

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: UP TO 7 DAYS PRIOR TO ILLNESS ONSET

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	
Clams				*Date Eaten (mm/dd/yyyy)*	*Location Purchased (restaurant/store name and address)*
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Location Consumed (restaurant/store name and address)*
Crab				*Date Eaten (mm/dd/yyyy)*	*Location Purchased (restaurant/store name and address)*
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Location Consumed (restaurant/store name and address)*
Lobster				*Date Eaten (mm/dd/yyyy)*	*Location Purchased (restaurant/store name and address)*
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Location Consumed (restaurant/store name and address)*
Mussels				*Date Eaten (mm/dd/yyyy)*	*Location Purchased (restaurant/store name and address)*
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Location Consumed (restaurant/store name and address)*
Oysters				*Date Eaten (mm/dd/yyyy)*	*Location Purchased (restaurant/store name and address)*
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Location Consumed (restaurant/store name and address)*
				Were the oysters part of a dish, like chef special, happy hour special, shooters, etc.? ☐ Yes ☐ No ☐ Unk	*If Yes, specify type of dish*
				Type of Oysters ☐ Altantic ☐ Blue Point ☐ Carlsbad ☐ Church Point ☐ Kumamoto ☐ Pacific ☐ Other: _____ ☐ Unk	*If Unknown, please provide any other details you can remember (Pacific NW, East Coast, Canada, etc.)*

First three letters of patient's last name: | | | |

FOOD HISTORY (continued)

Food Item	Yes	No	Unk	If Yes, Specify as Noted	
Shrimp				*Date Eaten (mm/dd/yyyy)*	*Location Purchased (restaurant/store name and address)*
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Location Consumed (restaurant/store name and address)*
Crawfish				*Date Eaten (mm/dd/yyyy)*	*Location Purchased (restaurant/store name and address)*
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Location Consumed (restaurant/store name and address)*
Other shellfish (specify):_____ _____				*Date Eaten (mm/dd/yyyy)*	*Location Purchased (restaurant/store name and address)*
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Location Consumed (restaurant/store name and address)*
Fish (specify): _____				*Date Eaten (mm/dd/yyyy)*	*Location Purchased (restaurant/store name and address)*
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*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?
☐ Completed ☐ In progress ☐ Not conducted

Is the Seafood Investigation Report Form attached to this report?
☐ Yes ☐ No ☐ Unk

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

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

EXPOSURE	Yes	No	Unk	If Yes, Specify as Noted	
Body of water				*Water type* ☐ Salt water ☐ Brackish water ☐ Unk ☐ Fresh water ☐ Other:_____	*Date of Exposure (mm/dd/yyyy)*
				Name and Location of Water	
Drippings from raw or live seafood				*Type of Seafood*	*Date of Exposure (mm/dd/yyyy)*
				Describe Exposure (e.g., handling or cleaning)	
Other contact with marine or freshwater life				*Type of Marine or Freshwater Life*	*Date of Exposure (mm/dd/yyyy)*
				Describe Exposure (e.g., handling or cleaning)	
Pre-existing wound at site of exposure				*Anatomic Site of Pre-existing Wound*	
New wound sustained at site of exposure				*Anatomic Site of New Wound*	

Other Exposures of Interest (describe)

First three letters of patient's last name: | | | |

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

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

ILL CONTACTS

Any contacts with similar illness (including household contacts)? ☐ Yes ☐ No ☐ Unk	*If Yes, specify details below.*

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?* ☐ Yes ☐ No ☐ 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?* ☐ Yes ☐ No ☐ Unk

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date (mm/dd/yyyy)*
First Reported By ☐ Clinician ☐ Laboratory ☐ Other (specify):_____		*Health education provided?* ☐ Yes ☐ No ☐ Unk	*Restriction / clearance needed?* ☐ Yes ☐ No ☐ Unk

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐ Yes ☐ No ☐ Unk	*Contact Name / Case Number*

First three letters of patient's last name: | | | |

DISEASE CASE CLASSIFICATION

Case Classification (see case definition on page 7)
☐ Confirmed ☐ Probable ☐ Not a case

OUTBREAK

Part of known outbreak?	*If Yes, extent of outbreak:*
☐ Yes ☐ No ☐ Unk	☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unk ☐ Other (specify):_____

Mode of Transmission	*Vehicle of Outbreak*	*Pattern 1 ID number*	*Pattern 2 ID number*
☐ Point source ☐ Person-to-person ☐ Unk ☐ Other:_____			

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.

OCCUPATION SETTING

- Childcare / Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- 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
- 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