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:

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Section 301 of the Public Health Service Act). Responses are voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary to understand and control cholera and other vibrio illnesses associated with contaminated water and food. Information that would permit identification of any individual will be held in confidence, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act.

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State:____ Year: _____ Age: ____ Sex: ____ Last Name:__ __ __

CHOLERA AND OTHER VIBRIO ILLNESS SURVEILLANCE REPORT

OMB 0920- 0728 Exp. Date 01/31/2019

CENTERS FOR DISEASE CONTROL AND PREVENTION

REPORTING HEALTH DEPARTMENT			SEND COMPLETED REPORT TO STATE INFECTION CONTROL 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
State	City	County/Parish	
☐☐			

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

5. NNDSS Case ID:

6. Race:
- ☐ American Indian/Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other
- ☐ Not provided/Unknown
- ☐ Asian

7. Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unk/Not Provided

8. 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)

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? ☐ Y ☐ N ☐ U If yes, State lab ID:_____

Specimen source:
☐Stool ☐Blood ☐Wound
☐Other (if wound or other, specify site): _____

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 applicable, species identified:
_____
Name/type of diagnostic test used:_____

2. Specimen two: Date collected: __ __ /__ __ /__ __ (MM/DD/YY) Received at public health laboratory? ☐ Y ☐ N ☐ U If yes, State lab ID:_____

Specimen source:
☐Stool ☐Blood ☐Wound
☐Other (if wound or other, specify site): _____

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 applicable, species identified:
_____
Name/type of diagnostic test used:_____

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

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

State:____ Year: _____ Age: ____ Sex: ____ Last Name:__ __ __

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 the patient travel outside their home state in the 7 days before illness began? ☐ Yes ☐ No ☐ Unk

5. 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 4.

State:____ Year: _____ Age: ____ Sex: ____ Last Name:__ __ __

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 travelled 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: _____ ☐

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:

Title/Agency: Tel:

State:____ Year: _____ Age: ____ Sex: ____ Last Name:__ __ __

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: __ __ /__ __ /__ __

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. Harvest area	Harvest date (MM/DD/YY)	Harvest area classification	
Area 1: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally approved ☐Conditionally restricted ☐Restricted ☐Prohibited	Description of product harvested: _____
Area 2: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally approved ☐Conditionally restricted ☐Restricted ☐Prohibited	Description of product harvested: _____

☐Check if additional harvest area page is attached

Person completing section 5:	Date completed:
Title/Agency:	Tel:

Additional harvest area page			
Harvest area	Harvest Date (MM/DD/YY)	Harvest Area Classification	
Area 3: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally Approved ☐Conditionally Restricted ☐Restricted ☐Prohibited	Description of product harvested: _____
Area 4: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally Approved ☐Conditionally Restricted ☐Restricted ☐Prohibited	Description of product harvested: _____
Area 5: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally Approved ☐Conditionally Restricted ☐Restricted ☐Prohibited	Description of product harvested: _____
Area 6: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally Approved ☐Conditionally Restricted ☐Restricted ☐Prohibited	Description of product harvested: _____
Area 7: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally Approved ☐Conditionally Restricted ☐Restricted ☐Prohibited	Description of product harvested: _____
Area 8: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally Approved ☐Conditionally Restricted ☐Restricted ☐Prohibited	Description of product harvested: _____
Area 9: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally Approved ☐Conditionally Restricted ☐Restricted ☐Prohibited	Description of product harvested:
Area 10: _____	Date : __ __ /__ __ /__ __	☐ Approved ☐Conditionally Approved ☐Conditionally Restricted ☐Restricted ☐Prohibited	Description of product harvested: _____

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? ☐ Y ☐ N ☐ U If yes, State lab ID:_____

Specimen source: ☐Stool ☐Blood ☐Wound ☐Other (if wound or other, specify site): _____	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 applicable, species identified: _____ Name/type of diagnostic test used:_____

4. Specimen four: Date collected: __ __ /__ __ /__ __ (MM/DD/YY) Received at public health laboratory? ☐ Y ☐ N ☐ U If yes, State lab ID:_____

Specimen source: ☐Stool ☐Blood ☐Wound ☐Other (if wound or other, specify site): _____	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 applicable, species identified: _____ Name/type of diagnostic test used:_____