Instructions for reporting to the Cholera and Other *Vibrio* Illness Surveillance (COVIS) system

CDC requests that either a COVIS case report form is completed or electronic data elements are submitted for all laboratory culture-confirmed cases of cholera and other *Vibrio* illnesses*,* as well as all cases for these pathogens with positive results from culture-independent diagnostic tests (CIDT). Cases of *Vibrio* illnesses that are classified as probable based on epidemiologic linkage to a confirmed or probable case may be submitted at the state's discretion. The current CSTE case definition for vibriosis is available at:
https://wwwn.cdc.gov/nndss/conditions/vibriosis/case-definition/2017

Confirmed cases of vibriosis

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. This includes cases with an initial positive result from a culture-independent diagnostic test that undergo reflex culture.

Confirmed cases of cholera

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

Probable cases of vibriosis

Based on supportive laboratory criteria:

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, that did not undergo culture or culture did not yield a species of the family *Vibrionaceae*.

OR

Based on epidemiologic linkage:

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

CDC requests that all *Vibrio* isolates are forwarded to the Enteric Disease Laboratory Branch. All suspected *V. cholerae* isolates should be forwarded immediately.

General reporting instructions

- Each patient should be represented by one case report form. Identification of multiple species of *Vibrio* in one patient should be reported on the same form.
- Notify CDC if additional information or laboratory results are identified after the case report form or case data elements have been submitted.
- COVIS data elements are submitted as a line list or by completed case report form.
    - Line lists and case report forms are submitted via email to COVISresponse@cdc.gov.

  - A data dictionary is available for states that choose to transmit data as a line list. CDC requests that data elements submitted as an electronic line list match the COVIS data element naming and values schemes detailed in the data dictionary, and be submitted as excel formatted files or csv. Requests for the data dictionary should be sent to COVISresponse@cdc.gov.
  - The case report form should be completed using the fillable PDF. If necessary, the case report form may be printed, completed by hand, and submitted via email or faxed to 404-235-1735.
- If a patient is lost to follow-up or unable to answer all questions, a case report form should still be submitted with any data available. Loss to follow-up can be indicated by checking the "Lost to follow-up" box in the additional comments on page 5, or adding "lost to follow-up" in the REPORTCOMMENT data element.
- This guidance provides a brief overview of COVIS reporting. Additional questions can be sent to COVISresponse@cdc.gov. Page and section number references are included for states using the COVIS form, and table references are included for states submitting data elements as an electronic line list.

Instructions for patient identifiers (page 1/no table)

This page is for use at the state and local level. **Do not include this information when forwarding the COVIS form to CDC**. Identifiers at the top of each page (state, year, age, sex, last name) are included to help both states and CDC identify loose form pages if they are completed at different times.

Instructions for reporting health department (page 3/demographics table)

- Include the state, city, and county of the reporting health department (not the case-patient).
- The health department reporting the case to CDC should be a health department in the state where the patient resides.

Instructions for patient case information (page 3, section 1/demographics table)

- Age in months does not need to be completed unless the patient is under one year of age.
- COVIS no longer collects the state identification number. Instead, include the NNDSS case identification number(s). The NNDSS case ID number is used to identify missing reports during the closeout process.
  - The NNDSS case investigation ID number, not the patient ID number should be recorded. If there is more than one case investigation ID for the same patient, include all case investigation IDs on the form.

Instructions for laboratory information (page 3, section 2/isolate table)

- COVIS collects laboratory data by specimen. Specimen information includes the source of the specimen, state laboratory ID number, culture results, and CIDT results. Both culture and CIDT results should be recorded for each specimen reported.
  - On the form, data for each specimen tested should be recorded under a separate specimen row. Two rows are included on the front of the form, and two additional rows are available on page 7. If the additional rows on page 7 are used, check the associated box under laboratory results on page 3 and attach the additional results.

    - In the data dictionary, each data element collected for a specimen is grouped by specimen number.

- The state laboratory ID number is used to link data between COVIS, the CDC reference laboratory, and PulseNet. If your state uses a different identifier when submitting specimens to CDC or transmitting information to PulseNet, please include that identifier instead.
- Use the three letter *Vibrio* species code found in the *Vibrio* species key at the top of section 2 or in the isolate table in the data dictionary when identifying species. These three letter codes should be used to identify cultured species.
    - **If multiple species of Vibrio are identified in one specimen, use the code "MUL" and list the individual species codes in the question "If species identified as multiple or other, specify".**
    - **If the species identified is not listed, use the code "OTH" and identify the species in the question "If species identified as multiple or other, specify".**
    - Laboratory information can be completed based on results from a clinical or state public health laboratory. If a specimen was tested at both a clinical laboratory and a public health laboratory, please include the result that is considered final by the state. This is often the public health laboratory result.
- Cholera isolate questions should only be completed for suspected or confirmed cases of toxigenic *Vibrio cholerae* O1 or O139. These data elements are included with the cholera exposure data elements in a separate cholera table.

Instructions for clinical information (page 4, section 3/syndrome table)

- Completion of the entire clinical information section is highly encouraged for confirmed cases.
- Completion of medical history is optional for probable cases. The other parts of the clinical information section should be completed for probable cases.

Instructions for epidemiology section (pages 4-5, section 4/exposures table)

- If the patient reports recent travel, only include the travel destination (city, state, and country) under the question "If yes [to travel outside of patient's home state], list destinations and dates". Any additional travel details that may be pertinent to the investigation should be included in the additional comments section.

Cholera exposure

- Only complete this section if toxigenic *V. cholerae* O1 or O139 is suspected.
- Cholera exposure elements are listed in a separate cholera table in the data dictionary, along with cholera isolate data elements.

Seafood consumption

- Only include information on seafood consumed during the **7 days before illness began**.

- If patient consumed the same seafood on multiple dates in the 7 days before illness began, indicate so in the column labeled "Multiple dates". If this is the case, the only date that should be specified on the form is **the most recent date of consumption** for that particular seafood.
- Further description of seafood items consumed may be provided in this section.

Water exposure

- If the patient reports more than one instance of water exposure in the 7 days before illness began, only include the most recent date of exposure.
- If the patient reports exposure to a body of water, please identify that body of water by name, city, and state, and country in question 1b on the form, or the data element LOCEXPOS.

Instructions for seafood investigation (page 6, section 5/seafood table)

- One copy of the seafood investigation form should be completed for each instance of seafood consumption investigated. If more than one type of seafood is investigated at a restaurant, please complete one investigation form per type of seafood. If a case report form is being submitted, indicate how many seafood investigations are included with the form at the top of this section.
- Seafood investigation data elements submitted as an electronic line list should include one line for each case seafood investigation. The seafood investigation identification number is the data element "INVESTID". The first seafood investigation is given the INVESTID "1" and numbering continues sequentially for additional investigations.
- If the seafood exposure occurred in another state coordinate the collection of investigation information with that state when possible.
- Raw shellfish investigations should be prioritized whenever possible.
- Seafood investigations are optional for probable cases.
- If the seafood investigation section will be completed by a separate agency, the case report form can be submitted prior to completion of the section and updated when additional seafood investigation information is available.

Product information

- If the product was harvested by the patient or a friend of the patient from a commercial harvest area, include the harvest area information under the "Source information" section.
- Products are considered fully cooked if they have been cooked to the following guidelines:
  - Shellfish in the shell:
    - Boil until the shells open and continue boiling 5 more minutes
    - Steam until the shells open and continue steaming for 9 more minutes
  - For shucked oysters:
    - Boil for at least 3 minutes
    - Fry in oil for at least 3 minutes at 375° Fahrenheit
    - Broil 3 inches from heat for 3 minutes
    - Bake at 450° Fahrenheit for 10 minutes

Commercial vendor information

- This section only needs to be completed if the product was consumed at a commercial establishment.
- If possible **provide at least the city and state** of the restaurant, oyster bar, or food store where the product was purchased or consumed.

Source information

- If seafood tags, invoices, or labels are available, please both fill out the relevant questions and attach photocopies to the COVIS form.
- The harvest area "Description of product harvested" should detail the name of the product as identified from the harvest tag, invoice, or label.
- If more than two harvest areas are associated with the seafood investigation, complete additional harvest area information on page 7, and check the box next to "Check if additional harvest area page is attached" at the bottom of page 6.

Instructions for additional harvest area and laboratory results (page 7)

- If no additional harvest area or laboratory results are reported, this page does need to be included with the form.

State:____ Year: ______ 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:

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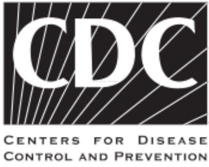
State:____ Year: ______ Age: ____ Sex: ____ Last Name:__ __ __



CHOLERA AND OTHER VIBRIO ILLNESS SURVEILLANCE REPORT

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

REPORTING HEALTH DEPARTMENT		
State	City	County/Parish
☐☐		

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

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

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:

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

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:

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

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	Culture	CIDT
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	Culture	CIDT
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:__________________________

FoodNet Case Report Form

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.

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

Ethnicity: ▫ Hispanic ▫ Not Hispanic

Race: ▫ American Indian / Alaskan ▫ Asian ▫ Black / African American ▫ Hawaiian / Pacific Islander ▫ White ▫ Refused ▫ Other: ____________________

Employer/School/Daycare: ____ **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: ____

INVESTIGATION

Investigation Start Date: ____/____/_______ **Investigator:** _______________________________________

Investigation Status: □ Open □ Closed **Date Assigned to Investigation:** ____/____/_______

SYMPTOM HISTORY

Date/Time of Illness Onset: ____/____/_______ ____:____ □ AM □ PM **First Symptom:** _____________________________

Symptoms: (Check all that apply)

□ Diarrhea	□ Bloody Diarrhea	□ Constipation
□ Vomiting	□ Nausea	□ Weight Loss
□ Fatigue	□ Chills	□ Fever (Max Temp: ______°F)
□ Headache	□ Abdominal Cramps	□ Muscle Aches
□ Other: ______________________		

If yes to diarrhea, date/time of diarrhea onset: ____/____/_______ ____:____ □ AM □ PM

If yes to vomiting, date/time of vomiting onset: ____/____/_______ ____:____ □ AM □ PM

As of today, are you still experiencing symptoms? □ Yes □ No □ Unknown

If recovered, date/time of recovery: ____/____/_______ ____:____ □ AM □ PM

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: