

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

Red boxes indicate required fields.

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Address Number & Street - Residence			Apartment / Unit Number		Ethnicity (check one)
City / Town		State	Zip Code		<input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Non-Hispanic / Non-Latino <input type="checkbox"/> Unk
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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
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)			
*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:

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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)			Date First Sought Medical Care (mm/dd/yyyy)
Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Fever				<i>Highest temperature (specify °F / °C)</i>
Chills				
Vomiting				
Diarrhea				<i>Max. number of stools in 24-hr period</i>
Bloody stools				
Muscle pain				
Cellulitis				<i>Location</i>
Bullae				<i>Location</i>
Shock (systolic BP < 90)				
<i>Other (specify)</i>				
PAST MEDICAL HISTORY				
History	Yes	No	Unk	If Yes, Specify as Noted
Alcoholism				
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>
Malignancy				<i>Type</i>
Renal disease				<i>Type</i>
Hematologic disease				<i>Type</i>
Immunodeficiency				<i>Type</i>
<i>Other (specify)</i>				

First three letters of patient's last name:

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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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, how many total hospital nights?
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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? <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

Treatment Type 1 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)
Treatment Type 2 <input type="checkbox"/> Antibiotic <input type="checkbox"/> Other	Treatment Name	Date Started (mm/dd/yyyy)	Date Ended (mm/dd/yyyy)

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

Specimen Type (e.g., stool, wound)	If wound, specify site	Type of Test (method) <input type="checkbox"/> PCR <input type="checkbox"/> Culture <input type="checkbox"/> Other (specify): _____
Vibrio Species isolated		Collection Date (mm/dd/yyyy)
<input type="checkbox"/> <i>V. alginolyticus</i> <input type="checkbox"/> <i>V. cholerae</i> non-O1, non-O139 <input type="checkbox"/> <i>V. fluvialis</i> <input type="checkbox"/> <i>V. metschnikovii</i> <input type="checkbox"/> <i>V. parahaemolyticus</i> <input type="checkbox"/> <i>V. cholerae</i> O1 <input type="checkbox"/> <i>V. cincinnatiensis</i> <input type="checkbox"/> <i>V. furnissii</i> <input type="checkbox"/> <i>V. mimicus</i> <input type="checkbox"/> <i>V. vulnificus</i> <input type="checkbox"/> <i>V. cholerae</i> O139 <input type="checkbox"/> <i>V. damsela</i> <input type="checkbox"/> <i>V. (Grimontia) hollisae</i> <input type="checkbox"/> <i>Vibrio</i> species - not identified		
If <i>Vibrio cholerae</i> O1 or O139, specify serotype, biotype, and whether toxigenic.		
Serotype <input type="checkbox"/> Inaba <input type="checkbox"/> Ogawa <input type="checkbox"/> Hikojima <input type="checkbox"/> Not done <input type="checkbox"/> Unk		Biotype <input type="checkbox"/> El Tor <input type="checkbox"/> Classical <input type="checkbox"/> Not done <input type="checkbox"/> Unk
Toxigenic <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, toxin positive by: <input type="checkbox"/> ELISA <input type="checkbox"/> Latex agglutination <input type="checkbox"/> PCR <input type="checkbox"/> Other (specify): _____	
Were other organisms isolated from the same specimen that yielded <i>Vibrio</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify organism(s)	
Was molecular fingerprinting (e.g., PFGE) done? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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. INCLUDE ANY SEAFOOD TRACEBACK INFO UNDER "SOURCE".)**

Food Item	Yes	No	Unk	If Yes, Specify as Noted
Clams				Date Eaten (mm/dd/yyyy) Location Purchased Location Consumed
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Crab				Date Eaten (mm/dd/yyyy) Location Purchased Location Consumed
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Lobster				Date Eaten (mm/dd/yyyy) Location Purchased Location Consumed
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Mussels				Date Eaten (mm/dd/yyyy) Location Purchased Location Consumed
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Oysters				Date Eaten (mm/dd/yyyy) Location Purchased Location Consumed
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Shrimp				Date Eaten (mm/dd/yyyy) Location Purchased Location Consumed
				Eaten raw? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

(continued on page 5)

First three letters of patient's last name:

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FOOD HISTORY (continued)						
Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Crawfish				<i>Date Eaten (mm/dd/yyyy)</i>	<i>Location Purchased</i>	<i>Location Consumed</i>
				<i>Eaten raw?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Source, if known (i.e., shellfish bed)</i>	
Other shellfish (specify): _____ _____				<i>Date Eaten (mm/dd/yyyy)</i>	<i>Location Purchased</i>	<i>Location Consumed</i>
				<i>Eaten raw?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Source, if known (i.e., shellfish bed)</i>	
Fish (specify): _____ _____				<i>Date Eaten (mm/dd/yyyy)</i>	<i>Location Purchased</i>	<i>Location Consumed</i>
				<i>Eaten raw?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Source, if known (i.e., shellfish bed)</i>	

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				<i>Water type</i> <input type="checkbox"/> Salt water <input type="checkbox"/> Brackish water <input type="checkbox"/> Unk <input type="checkbox"/> Fresh water <input type="checkbox"/> Other: _____	<i>Date of Exposure (mm/dd/yyyy)</i>
				<i>Name and Location of Water</i>	
Drippings from raw or live seafood				<i>Type of Seafood</i>	<i>Date of Exposure (mm/dd/yyyy)</i>
				<i>Describe Exposure (e.g., handling or cleaning)</i>	
Other contact with marine or freshwater life				<i>Type of Marine or Freshwater Life</i>	<i>Date of Exposure (mm/dd/yyyy)</i>
				<i>Describe Exposure (e.g., handling or cleaning)</i>	
Pre-existing wound at site of exposure				<i>Anatomic Site of Pre-existing Wound</i>	
New wound sustained at site of exposure				<i>Anatomic Site of New Wound</i>	

Other Exposures of Interest (describe)

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)

First three letters of patient's last name:

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ILL CONTACTS

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

ILL CONTACTS - DETAILS

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

NOTES / REMARKS

REPORTING AGENCY

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

EPIDEMIOLOGICAL LINKAGE

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

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

OUTBREAK

<i>Part of known outbreak?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, extent of outbreak:</i> <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): _____		
<i>Mode of Transmission</i> <input type="checkbox"/> Point source <input type="checkbox"/> Person-to-person <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	<i>Vehicle of Outbreak</i>	<i>Pattern 1 ID number</i>	<i>Pattern 2 ID number</i>

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STATE USE ONLY*State Case Classification*
 Confirmed Probable Not a case Need additional information
CASE DEFINITION**CHOLERA (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.

Probable: A clinically compatible illness without laboratory confirmation but with an environmental exposure that yielded *Vibrio* or with epi-link to a confirmed case (CDHS 2007).

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. Only confirmed cases should be reported to NNDSS by state health departments.

VIBRIOSIS – NON-CHOLERA VIBRIO SPP. (2010)**CLINICAL DESCRIPTION**

An infection of variable severity characterized by diarrhea and vomiting, primary septicemia, or wound infections. Asymptomatic infections may occur, and the organism may cause extraintestinal infections.

LABORATORY CRITERIA FOR DIAGNOSIS

Isolation of *Vibrio* spp. other than toxigenic *Vibrio cholerae* O1 or O139 from a clinical specimen.*

EXPOSURE

The most common mode of transmission is via raw or under cooked seafood, with oysters being the most frequently implicated source. Non-cholera *Vibrio* spp. may also be spread through contact with water, especially seawater.

CASE CLASSIFICATION

Confirmed: A case that meets the laboratory criteria for diagnosis. Note that species identification and, if applicable, serotype designation (i.e., *Vibrio cholerae* non-O1 / non-O139) should be reported.

Probable: A clinically-compatible symptomatic case that is epidemiologically linked to a confirmed case.

*Infections due to toxigenic *Vibrio cholerae* O1 or O139 are reportable as cholera (see current cholera case definition listed above).

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	
<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	
<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