

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

CHOLERA

Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 6

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name First Middle Suffix Maiden/Other Alias Birthdate (mm/dd/yyyy) SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Was isolate V.cholerae 01 or 0139? Was species of Vibrio confirmed at the State Laboratory of Public Health?

Table with 8 columns: Specimen Date, Specimen #, Specimen Source, Type of Test, Test Result(s), Description (comments), Result Date, Lab Name—City/State

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? If yes, symptom onset date (mm/dd/yyyy): CHECK ALL THAT APPLY: Fever, Dehydration, Shock, Headache, Muscle aches / pains, Skin lesions, Cellulitis, Nausea, Vomiting, Abdominal pain or cramps, Is there visible blood in the stool?, Melena

Diarrhea Describe (select all that apply): Bloody, Non-bloody, Watery, Other Maximum number of stools in a 24-hour period: Other symptoms, signs, clinical findings, or complications consistent with this illness

Laboratory Collection date P=Positive, O=Other, unknown, N=Negative, NT=Not tested, I=Indeterminate

Rapid dipstick test for V. cholerae O1 or O139 Toxigenic cholera culture (isolate) from (stool or vomitus) for V. cholerae 01 or 0139 Serotype/Group: Inaba, Ogawa, Hikojima, Not Done, Unknown Biotype: El Tor, Classical, Not Done, Unknown Serology for recent toxigenic cholera infection

The patient is: Resident NC, Resident of another state or US territory, Other, specify Did patient have a travel history during the 5 days prior to onset of symptoms? List travel dates and destinations: From to Does patient know anyone else with similar symptom(s) who had the same or similar travel history? List persons and contact information:

Additional travel information: Notes:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

REASON FOR TESTING

Why was the patient tested for this condition?

Symptomatic of disease

Screening of asymptomatic person with reported risk factor(s)

Exposed to organism causing this disease (asymptomatic)

Household / close contact to a person reported with this disease

Other

Unknown

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U

Specify _____

TREATMENT

Did the patient take an antibiotic as treatment for this illness? Y N U

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? Y N U

Hospital name: _____

City, State: _____

Hospital contact name: _____

Telephone: (____) _____ - _____

Admit date (mm/dd/yyyy): ____/____/____

Discharge date (mm/dd/yyyy): ____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action (i.e. work, child care, school, etc.)? Y N U

If yes, specify: _____

Were written isolation orders issued? Y N U

If yes, where was the patient isolated? _____

Date isolation started? _____

Date isolation ended? _____

Was the patient compliant with isolation? Y N U

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ____/____/____

Notes: _____

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U

Patient a child care worker or volunteer in child care? Y N U

Patient a parent or primary caregiver of a child in child care? Y N U

Is patient a student? Y N U

Type of school: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? Y N U

Give details: _____

BEHAVIORAL RISK & CONGREGATE LIVING

Has the patient ever used alcohol? Y N U

Pattern of use:

Casual Abuse Unknown

Timeframe of use (check all that apply):

During the last 6 months

During the last 7 to 12 months

More than 12 months ago

Unknown

During the 5 days prior to onset of symptoms did the patient live in any congregate living facilities, dormitories, barracks, camps, long term care facilities, commune, boarding school, shelter, etc.? Y N U

Name of facility: _____

Address: _____

City: _____ State: _____

Zip code: _____

Telephone: (____) _____ - _____

Dates of contact: _____

During the time period above, did the patient attend social gatherings or crowded settings? Y N U

If yes, specify: _____

MISC. OCCUPATIONS AND ENVIRONMENTAL EXPOSURES

Has the patient ever served in the military? Y N U

If yes, dates of service: _____

From _____ to _____

During the 5 days prior to onset of symptoms, did the patient work or have close contact to someone working in any of the following occupations or settings (check all that apply):

Healthcare worker

Childcare worker

Food service worker

Other sensitive occupation or setting

Unknown

Nature of work/contact: _____

Name of facility: _____

Address: _____

City: _____ State: _____

Zip code: _____

Telephone: (____) _____ - _____

FOOD RISK AND EXPOSURE

During the 5 days prior to onset of symptoms, did the patient do any of the following:

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)? Y N U

Type(s) of shellfish _____

Obtained from _____

Name _____

Location _____

Phone # of establishment _____

Brand name (if applicable) _____

Preparation method(s) _____

Unknown

Was this food undercooked or raw? Y N U

Handled/consumed on (mm/dd/yyyy): ____/____/____

Until (mm/dd/yyyy): ____/____/____

CONTINUED ON NEXT PAGE

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

FOOD RISK AND EXPOSURE (CONTINUED)

Frequency:
 Once
 Multiple times within this time period
 Daily

Time consumed _____ AM PM
Amount consumed _____

Was this shellfish the most likely source of illness? Y N U
Was shellfish imported from another country? Y N U
Exporting country _____
Were clams eaten Y N U
How were they distributed to retail outlet?
 Shell stock (sold in shell)
 Shucked
 Unknown
 Other

Date restaurant/outlet received seafood: _____
Was restaurant/retail outlet inspected as part of investigation? Y N U
Are shipping tags available? Y N U
Shippers who handled suspect seafood (include certification numbers if on tags) _____

Source of seafood: _____
Harvest date (mm/dd/yyyy): ____/____/____
Harvest site status:
 Approved Conditional
 Prohibited Other

Maximum ambient temperature: _____ °F °C
Date measured (mm/dd/yyyy): ____/____/____
Surface water temperature: _____ °F °C
Date measured (mm/dd/yyyy): ____/____/____
Salinity (ppt): _____
Date measured (mm/dd/yyyy): ____/____/____
Total rainfall (inches in previous 5 days): _____
Date measured (mm/dd/yyyy): ____/____/____
Fecal coliform count: _____
Date measured (mm/dd/yyyy): ____/____/____
Was there evidence of cross-contamination, or improper storage or holding temperatures at any point? Y N U
Specify deficiencies _____

During the 5 days prior to onset of symptoms, did the patient:
Handle/eat finfish (i.e. Tuna, Mackerel, Skip Jack, Amber Jack, Bonito, mahi-mahi / dorado, Blue fish, Salmon, Puffer fish, Porcupine fish, Ocean sunfish, sushi)? Y N U

Type(s) of fish _____

Obtained from _____
Name _____
Location _____
Phone # of establishment _____
Brand name (if applicable) _____
Preparation method(s) _____
 Unknown
Was this food undercooked or raw?.. Y N U
Handled/consumed on (mm/dd/yyyy): ____/____/____
Until (mm/dd/yyyy): ____/____/____
Frequency:
 Once
 Multiple times within this time period
 Daily

Time consumed _____ AM PM
Amount consumed _____
Was this seafood the most likely source of illness? Y N U
During the 5 days prior to onset of symptoms, did the patient drink any bottled water? Y N U
Specify type/brand: _____
Describe the source of drinking water used in the patient's home. Check all that apply:
 Bottled water supplied by a company
 Bottled water purchased from a grocery store
 Municipal supply (city water)
 Well water
Was the patient's drinking water source the most likely cause of illness? Y N U
If yes, give factors contributing to water contamination: _____

During the 5 days prior to onset of symptoms, did the patient:
Eat a known contaminated food product? Y N U
Specify food type: _____
Obtained from: _____
Name: _____
Location: _____
Brand name (if applicable): _____
Consumed on (mm/dd/yyyy): ____/____/____
Until (mm/dd/yyyy): ____/____/____
Frequency:
 Once
 Multiple times within this time period
 Daily

Eat at a group meal? Y N U
Specify group: _____
Name: _____
Location: _____
Brand name (if applicable): _____
Consumed on (mm/dd/yyyy): ____/____/____
Until (mm/dd/yyyy): ____/____/____
Frequency:
 Once
 Multiple times within this time period
 Daily

Eat food from a restaurant? Y N U
Restaurant: _____
Location: _____
Brand name (if applicable): _____
Consumed on (mm/dd/yyyy): ____/____/____
Until (mm/dd/yyyy): ____/____/____
Frequency:
 Once
 Multiple times within this time period
 Daily

Did the patient have a vibrio wound infection? Y N U
Was the patient's skin exposed to water or aquatic organisms? Y N U
Location _____
If skin exposed, did patient sustain a wound during this exposure, or have a pre-existing wound?
 Yes, sustained wound
 Yes, had pre-existing wound
 Yes, uncertain is wound new or old
 No
 Unknown
How did this occur? _____

Body site _____
Was the patient exposed to any of the following 4 days before illness began (choose all that apply):
 Raw seafood
 Cooked seafood
 Foreign travel
 Other persons with cholera or cholera-like illness
 Street vended food
 Other, specify _____

Was the patient's skin exposed to drippings from raw or live seafood? Y N U

Notes:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

WATER EXPOSURE

During the 5 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water, including aerosolized water in household, community or health care settings? Y N U

Activity(ies): _____

Type(s) of water:
 Freshwater (stream, river, pond, lake, pool)
 Estuarine or marine water (brackish or salt water sound, estuary, ocean)
 On (mm/dd/yyyy): ____/____/____

Route of exposure (agent entry) for recreational exposure (check all that apply):
 Accidental ingestion Inhalation
 Intentional ingestion Other
 Skin contact Unknown

Water source(s) / setting(s) (select all sources and settings that apply):
 Spring / hot spring
 River, stream
 Lake, pond, reservoir
 Estuary / tidal area (brackish / salty water)
 Ocean
 Pool
 Fountain
 Hot tub
 Whirlpool / spa pool
 Other
 Unknown

Factors contributing to water contamination
 High bather density / load
 Fecal accident by bather(s)
 Use by diapered / toddler-aged children
 Overflow or release of sewage (observed or signage)
 Flooding / heavy rains
 Stagnant water
 Water temperature >= 30 C (86 F)
 Chemical pollution
 Algal bloom
 Animal feces observed near site
 Agricultural / animal production in watershed
 Unprotected watershed
 Other
 Unknown

Was water treatment of source or setting provided? Y N U

Please specify water treatment(s) (check all that apply):
 Settling (sedimentation)
 Coagulation and / or flocculation
 Filtration at purification plant (not including home filters)
 Disinfection
 Other
 Unknown

CASE INTERVIEWS / INVESTIGATIONS

Was the patient interviewed? Y N U

Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U

Who was interviewed? _____

Were health care providers consulted? Y N U

Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U

Specify reason if medical records were not reviewed: _____

Notes on medical record verification: _____

GEOGRAPHICAL SITE OF EXPOSURE

If known, in what type of setting was the pt. MOST LIKELY exposed?
 Food
 Home
 Work
 School
 Doctor's office
 Hospital
 Hospital ER
 Laboratory
 Long-term care
 Military
 Hotel
 Social gathering
 Travel (bus, car, train, plane, etc.)
 International
 Community
 Other, specify: _____
 Unknown

In what country, state, city or county did exposure occur? _____

Is the patient part of an outbreak of this disease? Y N

VACCINE

Has patient/contact ever received Cholera Vaccine? Y N U

If yes, provide the type of vaccine:
 oral parenteral

Date of vaccination (mm/dd/yyyy): ____/____/____

Source of vaccination information: _____

Note: any vaccine verified by a medical record should be recorded in the NCIR.

Cholera (*Vibrio cholerae*)

1996 CDC Case Definition

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