

**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.

CRYPTOSPORIDIOSIS

**Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 56**

**ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease.
Enter all information from this form into the NC EDSS question packages.**

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.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? Y N U

If yes, symptom onset date (mm/dd/yyyy): / /

Fever Y N U

Yes, subjective No

Yes, measured Unknown

Highest measured temperature _____

Fever onset date (mm/dd/yyyy): / /

Loss of appetite (anorexia) Y N U

Weight loss with illness Y N U

Nausea Y N U

Vomiting Y N U

Abdominal pain or cramps Y N U

Diarrhea Y N U

Maximum number of stools in a 24-hour period: _____

Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U

Specify: _____

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): / /

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): / /

Autopsy performed? Y N U

Patient autopsied in NC? Y N U

County of autopsy: _____

Autopsied outside NC, specify where: _____

Source of death information (select all that apply):

Death certificate

Autopsy report final conclusions

Hospital/discharge physician summary

Other

PREDISPOSING CONDITIONS

HIV/AIDS Y N U

Any immunosuppressive conditions (other than HIV/AIDS) Y N U

Please specify: _____

Malignancy Y N U

Receiving treatment or taking any medications Y N U

Chemotherapy

Immunosuppressive therapy, including anti-rejection therapy

Radiotherapy

Systemic steroids/corticosteroids, including steroids taken by mouth or injection

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) Y N

If yes, specify: _____

TRAVEL/IMMIGRATION

The patient is:

Resident of North Carolina

Resident of another state or US territory

None of the above

Did patient travel during the 12 days prior to onset of symptoms? Y N U

List travel dates and destinations:

From / / to / /

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U

Name: _____

Additional travel/residency information:

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CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U
 Name of care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (____) _____

Patient wears diapers or shares a classroom with diapered children? Y N U
 Who wears diapers?
 Patient Classmate
 Give names of all child health care arrangements attended by the patient that involve diapering (patient wears diapers or other children in the same group wear diapers).

Patient a child care worker or volunteer in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (____) _____

Patient a parent or primary caregiver of a child in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (____) _____

Notes:

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 12 days prior to onset of symptoms, did the patient have exposure to a diapered or incontinent child or adult? Y N U
 Nature of exposure _____
Other exposures? Y N U
 Specify _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 If yes, specify: _____

During the 12 days prior to onset of symptoms, did the patient have contact with sewage or human excreta? Y N U

FOOD RISK AND EXPOSURE

During the 12 days prior to onset of symptoms, did the patient eat any raw or undercooked seafood or shellfish (i.e., raw oysters, sushi, etc.)? Y N U
 Specify type of seafood/shellfish _____
 Specify place of exposure _____

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

Where does the patient/patient's family typically buy groceries?
 Store name: _____
 Store city: _____
 Shopping center name/address: _____

During the 12 days prior to onset of symptoms, did the patient:
Eat any food items that came from a produce stand, flea market, or farmer's market? Y N U
 Specify source: _____
Eat any food items that came from a store or vendor where they do not typically shop for groceries? Y N U
 Specify source(s): _____

During the 12 days prior to onset of symptoms, was the patient:
Employed as food worker? Y N U
 Where employed? _____
 Specify job duties: _____
 What dates did the patient work? _____

Employed as food worker while symptomatic? Y N U
 Where did the patient work? _____
 What dates did the patient work? _____
 What day did the patient return to food service work?
 Date: _____
 Where did patient return to work? _____

Non-occupational food worker?
 (e.g. potlucks, receptions) during contagious period Y N U
 Where employed? _____
 Specify dates worked during contagious period: _____

Comments:

Health care worker or child care worker handling food or medication in the contagious period ? Y N U
 Where employed? _____
 Specify dates worked during contagious period: _____

Comments:

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FOOD RISK AND EXPOSURE (CONTINUED)

During the 12 days prior to onset of symptoms, did the patient:

Drink unpasteurized milk?.....Y N U
Specify type of milk:
 Cow
 Goat
 Sheep
 Other, specify: _____
 Unknown

Eat any other unpasteurized dairy products?.....Y N U
Specify type of product:
 Queso fresco, Queso blanco or other Mexican soft cheese
 Butter
 Cheese from raw milk, specify: _____
 Food made from raw dairy product, specify: _____
 Other, specify: _____

Drink unpasteurized juices or ciders?Y N U
Specify juices or ciders:
 Apple
 Orange
 Other, specify: _____

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

Eat raw fruit?.....Y N U
Specify raw fruit:
 Apples
 Bananas
 Oranges
 Grapes, specify: _____
 Pears
 Peaches
 Berries, specify _____
 Melon,specify _____
 Mangoes
 Other, specify: _____

Eat raw salads or vegetables other than sprouts?.....Y N U
Specify raw salad or vegetable:
 Bagged salad greens without toppings, type: _____
 Salad with toppings, specify: _____
 Lettuce, type: _____
 Spinach
 Tomatoes, type: _____
 Cucumbers
 Mushrooms, type: _____
 Onions, type: _____
 Potatoes, type: _____
 Other, specify: _____

Eat sprouts?.....Y N U
Specify type of sprouts:
 Alfalfa Clover Bean
 Other, specify: _____
 Unknown

Eat fresh herbs?Y N U
Specify:
 Basil Thyme
 Parsley Cilantro
 Oregano Rosemary
 Cumin
 Other, specify: _____

WATER EXPOSURE

During the 12 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water (including 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) _____
 Until (mm/dd/yyyy) _____
 Frequency
 Once
 Multiple times within this time period
 Daily

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

Specify type of water filtration method used:

Specify type of water disinfection used:

OUTDOOR EXPOSURE

During the 12 days prior to onset of symptoms, did the patient participate in any outdoor activities?.....Y N U
If yes, specify and give details: _____

What was location of the exposure?
 North Carolina
 County _____
 US (not North Carolina)
 State _____
 Foreign
 Country _____

Did patient skin/eviscerate (gut) wild animal or have contact with wild animal carcass? Y N U
Please specify animal(s): _____

ANIMAL EXPOSURE

During the 12 days prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)?Y N U
If yes, specify and give details: _____

Household pets?Y N U
Specify: _____

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/distributor?Y N U
If yes, specify and give details: _____

Did patient handle any animals?Y N U
Species: _____
 Did it/they appear sick?Y N U

Did patient work with animal importation?Y N U
If yes, specify and give details: _____

Did patient / household contact work at, live on, or visit a farm, ranch, or dairy?Y N U
If yes, specify and give details: _____

Was patient exposed to animals associated with agriculture or aviculture (domestic/semi-domestic animals)?Y N U
If yes, specify and give details: _____

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ANIMAL EXPOSURE (CONTINUED)

During the 12 days prior to onset of symptoms, did the patient:

Have exposure to animal excreta (urine or feces)? Y N U
If yes, specify and give details:

Work at or visit a slaughterhouse (abattoir), meat-packing plant, poultry or wild game processing facility? Y N U
If yes, specify and give details:

Has patient otherwise slaughtered animals or been a butcher, meat cutter, or meat processor? Y N U
If yes, specify and give details:

Did the patient work at or visit a fair with livestock or a petting zoo? Y N U
If yes, specify and give details:

Did the patient work at or visit a zoo, zoological park, or aquarium? Y N U
If yes, specify and give details:

Did patient own, work at, or visit a private or public aviary (bird exhibit) or live bird market? Y N U
If yes, specify and give details:

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

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

In NC
City _____
County _____

Outside NC, but within US
City _____
State _____
County _____

Outside US
City _____
Country _____

Unknown

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

Notes regarding setting of exposure:

Cryptosporidiosis (*Cryptosporidium*)

2009 Case Definition

Clinical description

An illness characterized by watery diarrhea, abdominal cramps, loss of appetite, low-grade fever, nausea and vomiting. The disease can be prolonged and life-threatening in severely immunocompromised persons.

Laboratory criteria for diagnosis

Laboratory-confirmed cryptosporidiosis shall be defined as the detection of a member of the genus *Cryptosporidium* by one of the following methods:

1. Organisms in stool, intestinal fluid, or tissue samples or biopsy specimens
2. in intestinal fluid or small-bowel biopsy specimens, or
3. Antigens in stool or intestinal fluid, or
4. Nucleic acid by PCR in stool, intestinal fluid, or tissue samples or biopsy specimens

Case classification

Confirmed: a case that meets the clinical description and at least one of the criteria for laboratory-confirmation as described above. When available, species designation and molecular characterization should be reported.

Probable: a case that meets the clinical description and that is epidemiologically linked to a confirmed case.