



Cryptosporidium Report Form

INTERVIEW

EpiTrax # _____ Interviewer Name: _____

Number of Call Attempts: _____ Date of Interview (must enter MM/DD/YYYY): _____

Follow-up Status: Interviewed Refused Interview Lost to Follow-Up*
Respondent was: Self Parent Spouse Other, *Specify*: _____

*At least three attempts at different times of the day should be made before the considered lost to follow-up.

DEMOGRAPHICS

Birth Gender: Male Female
Date of Birth: _____
Age: _____
Hispanic/Latino Origin: Yes No Unknown
How would you describe your race? White Black/African American American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander Other _____ Unknown

CLINICAL

Did you have any symptoms? Yes No Unknown
If yes, turn to page 3 and record specific symptoms under Investigation.

What date did you start to have symptoms of illness? _____ Onset Date: _____ Onset Time: _____

Calculate Cryptosporidium exposure time frame **12 days** before onset

Do not read to patient; however, use the information to assess exposure.

Exposure period: _____

Did you recover? Yes No Unknown
Were you hospitalized? Yes No Unknown

If Yes, Recovery Date: _____ If Yes, Hospital Name: _____

Time Recovered: _____ Admit date: _____ Discharge Date: _____

Died?

Yes No Unknown

If Yes, Date of Death: _____

Are you pregnant?

Yes No Unknown

If Yes, Expected Delivery Date: _____

Did you receive antiparasitic medication for this illness?

Yes No Unknown

Medication Name	Date Started	Date Ended

Additional Clinical Notes:

EPIDEMIOLOGICAL

Occupation: _____

Check all that apply: Volunteer Unemployed Retired

Is the patient a:

Food Handler? Yes No Unknown

Facility Name: _____
 Address: _____
 Telephone #: _____

Healthcare Worker? Yes No Unknown

Facility Name: _____
 Address: _____
 Telephone #: _____

Group Living? Yes No Unknown

Facility Name: _____
 Address: _____
 Telephone #: _____

Day Care Attendee? Yes No Unknown

Facility Name: _____
 Address: _____
 Telephone #: _____

Day Care Employee? Yes No Unknown

Facility Name: _____
 Address: _____
 Telephone #: _____

School Attendee? Yes No Unknown Facility Name: _____
 Address: _____
 Telephone #: _____

School Employee? Yes No Unknown Facility Name: _____
 Address: _____
 Telephone #: _____

Attend Lab Class at School? Yes No Unknown Facility Name: _____
 Address: _____
 Telephone #: _____

If Yes to any above, did you work or attend while ill? Yes No Unknown

If Yes, Dates Worked or Attended/Notes:

INVESTIGATION

A. Clinical Symptoms

Reasons for testing* Symptomatic Refugee Screening International Adoption
 *If refugee or international adoption, what is the country of origin? _____
 Date arrived in U.S. _____

Diarrhea? Yes No Unknown If yes, maximum # of stools/24 hours ____

Vomiting? Yes No Unknown

Abdominal Cramps or Pain? Yes No Unknown

Nausea? Yes No Unknown

Loss of Appetite? Yes No Unknown

Weight Loss? Yes No Unknown

Fever? Yes No Unknown If yes, highest measured temperature (°F) ____

Other Symptoms? Yes No Unknown If yes, specify: _____

Do you have an underlying immunodeficiency? Yes No Unknown If yes, specify: _____

B. Water Exposure

In the 12 days before illness, what was your source of drinking water:

- At Home? Municipal
 Well
 Bottle
 Commercial Delivery
 Other

- At Work/School? Municipal
 Well
 Bottle
 Commercial Delivery
 Other

If other, specify _____

If other, specify _____

Recent plumbing/construction work done on water system at home? Yes No Unknown

If yes, specify: _____

Did you drink or accidentally ingest any untreated water (e.g., pond, stream, spring, river or lake)? Yes No Unknown

If yes, please source(s) of untreated water, location(s) of untreated water and date(s) of exposure: _____

Did you participate in other water activities such as fishing, kayaking, canoeing, or other boating? Yes No Unknown

If yes, specify: _____

Did you swim or wade in any recreational water in the 12 days **before** onset of symptoms? Yes No Unknown

If yes to the above question, please provide additional information below:

Kiddie/Inflatable	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Public/City pool	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Hot tub/Spa/Jacuzzi	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Water park	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____

Splash pad/Park	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Hotel/Motel pool or spa	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Fountain/Interactive water feature	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Irrigation/Canal water	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Sprinklers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Any natural water (lake, river, reservoir, pond, stream, ocean or hot spring)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Other recreational water	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____

Did you have exposure to recreational water **after** onset of illness? Yes No Unknown

If yes to the above question, please provide additional information below:

Kiddie/Inflatable	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Public/City pool	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Hot tub/Spa/Jacuzzi	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____

Water park	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Splash pad/Park	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Hotel/Motel pool or spa	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Fountain/Interactive water feature	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Irrigation/Canal water	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Sprinklers	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Any natural water (lake, river, reservoir, pond, stream, ocean or hot spring)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____
Other recreational water	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location/Date 1. _____ 2. _____ 3. _____

C. Animal Exposure

Did you visit or live on a farm in the 12 days prior to illness? Yes No Unknown

Did you visit any animal exhibits? (i.e., petting zoo, county fair, etc.) Yes No Unknown

Did you have exposure to manure? Yes No Unknown

Did you have contact with any of the following:

- Dog/Puppy Chick/Duckling Rodent (mouse, hamster, guinea pig, etc.)
 Cat/Kitten Cow/Calf Chicken Sheep
 Pig Horse Exotic bird (parakeet, parrot, etc.)
 Other If other, please specify: _____

Were any of these animals recently acquired or recently ill? Yes No Unknown

If yes, specify details: _____

D. Other Exposure—Risk Factors

Did you obtain any produce at a farm or farm stand (farmers market)? Yes No Unknown

Does the patient practice gardening? Yes No Unknown

If yes, do you wash your hands after gardening? Yes No Unknown

Did you have any contact with human feces, such as
diapering, caring for an incontinent person, or through
sexual activity? Yes No Unknown

Did you have contact with anyone who had similar
symptoms or was diagnosed with Cryptosporidiosis? Yes No Unknown

If yes, list contact, with relationship to case, age, onset date, and predominant symptoms. This information will be reported under “Contacts” in EpiTrax:

<i>Contact Name</i>	<i>Relationship</i>	<i>Age</i>	<i>Onset Date</i>	<i>Predominant Symptoms</i>

Other Exposure—Travel History

Did you travel outside of the USA in the 15 days prior to onset of illness? Yes No Unknown

Location traveled to (i.e., City/Country Resort Information) and Dates traveled: _____

Traveled outside of Kansas, but inside USA?

Yes No Unknown

Location traveled to (i.e., City and State Hotel Information) and Dates traveled: _____

Traveled outside of county, but inside Kansas?

Yes No Unknown

Cities traveled to in Kansas and Dates: _____

Public Health Interventions (Check all that apply)

Hygiene Education Provided

Daycare Inspection

Follow-up of other household member(s)

Work or Daycare restriction for case

Other

If other, specify: _____

That completes the interview, thank you for taking the time to answer all these questions. Your responses may be helpful in preventing others from becoming sick.

Additional notes: _____
