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*

□ 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

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

Exposure period: __________

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

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: __________
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              Facility Name: _____________________________
               □ No               Address: _____________________________
               □ Unknown           Telephone #: _____________________________

Healthcare Worker? □ Yes              Facility Name: _____________________________
                   □ No               Address: _____________________________
                   □ Unknown           Telephone #: _____________________________

Group Living?    □ Yes              Facility Name: _____________________________
                  □ No               Address: _____________________________
                  □ Unknown           Telephone #: _____________________________

Day Care Attendee? □ Yes              Facility Name: _____________________________
                  □ No               Address: _____________________________
                  □ Unknown           Telephone #: _____________________________

Day Care Employee? □ Yes              Facility Name: _____________________________
                   □ No               Address: _____________________________
                   □ Unknown           Telephone #: _____________________________

Died? □ Yes □ No □ Unknown
If Yes, Date of Death: _____________________________

Are you pregnant? □ Yes □ No □ Unknown
If Yes, Expected Delivery Date: _____________________________
School Attendee? □ Yes Facility Name: _____________________________
              □ No Address: _________________________________
              □ Unknown Telephone #: ________________________

School Employee? □ Yes Facility Name: _____________________________
              □ No Address: _________________________________
              □ Unknown Telephone #: ________________________

Attend Lab Class at School? □ Yes Facility Name: _____________________________
              □ No Address: __________________________________
              □ Unknown 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**

<table>
<thead>
<tr>
<th>Reasons for testing*</th>
<th>Symptomatic</th>
<th>Refugee Screening</th>
<th>International Adoption</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes □ No □ Unknown</td>
<td>*If refugee or international adoption, what is the country of origin?___________________________ Date arrived in U.S. ____________</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>At Home?</th>
<th>At Work/School?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Municipal</td>
<td>□ Municipal</td>
</tr>
<tr>
<td>□ Well</td>
<td>□ Well</td>
</tr>
<tr>
<td>□ Bottle</td>
<td>□ Bottle</td>
</tr>
<tr>
<td>□ Commercial Delivery</td>
<td>□ Commercial Delivery</td>
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<tr>
<td>□ Other</td>
<td>□ Other</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Kiddie/Inflatable</th>
<th>Location/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>1. ________________</td>
</tr>
<tr>
<td>□ No</td>
<td>2. ________________</td>
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<tr>
<td></td>
<td>3. ________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public/City pool</th>
<th>Location/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>1. ________________</td>
</tr>
<tr>
<td>□ No</td>
<td>2. ________________</td>
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<tr>
<td></td>
<td>3. ________________</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Hot tub/Spa/Jacuzzi</th>
<th>Location/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>1. ________________</td>
</tr>
<tr>
<td>□ No</td>
<td>2. ________________</td>
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<td></td>
<td>3. ________________</td>
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<table>
<thead>
<tr>
<th>Water park</th>
<th>Location/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes</td>
<td>1. ________________</td>
</tr>
<tr>
<td>□ No</td>
<td>2. ________________</td>
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<tr>
<td></td>
<td>3. ________________</td>
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<td>Location/Date</td>
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<td>3.______________</td>
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</table>

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:

<table>
<thead>
<tr>
<th>Location/Date</th>
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<td>2.______________</td>
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<tr>
<td>3.______________</td>
</tr>
</tbody>
</table>
| Water park | □ Yes □ No | Location/Date  
1.________________________  
2.________________________ 
3.________________________ |
| Splash pad/Park | □ Yes □ No | Location/Date  
1.________________________  
2.________________________  
3.________________________ |
| Hotel/Motel pool or spa | □ Yes □ No | Location/Date  
1.________________________  
2.________________________  
3.________________________ |
| Fountain/Interactive water feature | □ Yes □ No | Location/Date  
1.________________________  
2.________________________  
3.________________________ |
| Irrigation/Canal water | □ Yes □ No | Location/Date  
1.________________________  
2.________________________  
3.________________________ |
| Sprinklers | □ Yes □ No | Location/Date  
1.________________________  
2.________________________  
3.________________________ |
| Any natural water (lake, river, reservoir, pond, stream, ocean or hot spring) | □ Yes □ No | Location/Date  
1.________________________  
2.________________________  
3.________________________ |
| Other recreational water | □ Yes □ 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:

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Relationship</th>
<th>Age</th>
<th>Onset Date</th>
<th>Predominant Symptoms</th>
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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: _________________________________________________________

_______________________________________