Harmful Algal Bloom (HAB)-Related Report Form (Human)

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*

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

Respondent was:
- ☐ Self
- ☐ Parent
- ☐ Spouse
- ☐ Other, *Specify:*___________________

Comments:

____

____

____

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

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

Date Diagnosed: ___________________________

Were you hospitalized? ☐Yes ☐No ☐Unknown

Hospital Name: ______________________________

Admission Date: ________ Discharge Date: ________

Number of days hospitalized: _______

Died? ☐Yes ☐No ☐Unknown

If yes, date of death: _______________

Are you pregnant? ☐Yes ☐No ☐Unknown

If yes, expected delivery date: ____________

INVESTIGATION

A. Symptoms & Signs

Did the patient have symptoms? ☐Yes ☐ No ☐ Unknown

- If yes, what symptoms did the case first experience? ___________________________________
  ____

General

Fatigue?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Fever?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Loss of appetite?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Malaise?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Other?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________

HEENT

Earache?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Headache?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Conjunctivitis?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Nasal congestion?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Sore throat?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________

Other?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________

Respiratory

Cough?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Short of breath?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Wheezing?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Chest tightness?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Sore throat?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Other?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________

Cardiovascular

Chest pain?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Irregular beat?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Cyanosis?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
		If yes, check all that apply:	☐ Arms ☐ Legs ☐ Mouth
Pale (arms/legs)?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Other?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________

Gastrointestinal

Nausea?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Diarrhea?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Vomiting?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Pain (up R quadrant)?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Bad taste in mouth?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Other?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________

Genitourinary

Dark urine?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Blood in urine?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________
Other?	☐Yes ☐ No ☐ Unknown	Onset: __________	Duration: ___________

Musculoskeletal

Muscle pain?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Joint pain?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Difficulty walking?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Other?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________

Neurological

Confusion?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Memory loss?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Seizure?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Coma?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Numbness?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Weakness?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Paralysis?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Vertigo?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Tingling/burning?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Vision disturbance?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Other?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________

Dermatologic

Itching?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Blisters?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________
Rash?	☐Yes ☐ No ☐ Unknown	Onset: ___________	Duration: ____________

If yes, check all that apply:

☐ Left hand/arm	☐ Right hand/arm
☐ Left foot/leg	☐ Right foot/leg
☐ Face	☐ Neck
☐ Chest	☐ Back
☐ Under swimsuit	☐ Other: ______________

Describe the appearance of the rash: ______________________________________

____

____

Jaundiced? ☐Yes ☐ No ☐ Unknown Onset: __________ Duration: ___________

Other? ☐Yes ☐ No ☐ Unknown Onset: __________ Duration: ___________

Did the case have multiple exposures? ☐Yes ☐ No ☐ Unknown If yes, when: ____________________________

If yes, did symptoms reoccur? ☐Yes ☐ No ☐ Unknown

Other symptoms: ____

____

____

B. Exposures

Date of exposure: _______________________ Time of exposure: ___________________________________

Source of exposure: ☐ Food ☐ Brackish water ☐ Sea water ☐ Fresh water ☐ Drinking water ☐ Other: ___________

Water Exposures

What was the activity at the time of exposure?

☐ Swimming ☐ Wading ☐ Boating
☐ Fishing ☐ Tubing ☐ Skiing
☐ Personal Watercraft ☐ Unknown ☐ Other: _____

Category of activity? ☐ Work-related ☐ Recreational ☐ Accidental

Water body of exposure?

Water body name: _____________________________________

Water body management:

☐ Private
☐ Public (State)
☐ Public (Federal)
☐ Public (City)
☐ Other, specify: ___________

County (two letter abbreviated code) where exposure occurred: ______________________

Route of exposure? ☐ Inhalation ☐ Ingestion ☐ Dermal contact ☐ Unknown ☐ Other

Body areas in contact with water? ☐ Head or face ☐ Arms or hands ☐ Legs or feet ☐ Neck ☐ Trunk ☐ Unknown ☐ Other: __________

Algae Bloom Information

HAB System Record #: __________________ Most Recent or Relevant Water Test Date: ________________

Species: __________________ Cell Count: _____________________ Toxin Concentration: _____________

Lake Status at the time of exposure (+/- 7 days): ☐ Warning ☐ Advisory ☐ Closed ☐ Open

Comments regarding water exposure: ____

____

____

____

Environmental Conditions – Animals/Water

Fish	☐ Dead	If yes, indicate #: _____	Other: ____	☐ Dead	If yes, indicate #: _____
	☐ Sick	If yes, indicate #: _____		☐ Sick	If yes, indicate #: _____

Did the water have an unusual odor? ☐Yes ☐ No

What was the water movement? ☐Moving ☐ Stagnant

Was scum present? ☐Yes ☐ No

C. Medical Information

Is the patient currently taking any of the following:

☐ Dietary supplement made from blue-green algae or Super Blue Green?

☐ Herbal supplements or drink herbal teas?

If yes, please explain: ____

☐ OTC pain medicine containing acetaminophen (5 weeks or more)

☐ Other prescription medication, OTC medication, or supplements?

If yes, specify: ____

Other health conditions present?

- ☐ Flu in the past 2 weeks
- ☐ Asthma
- ☐ Chronic respiratory disease
- ☐ Chronic skin disease
- ☐ Diabetes mellitus
- ☐ Heart disease
- ☐ Immunodeficiency disorder
- ☐ Liver disease (i.e., hepatitis, cirrhosis, fatty liver, jaundice)
- ☐ Malignancy
- ☐ Neurologic disorders
- ☐ Psychological disorders
- ☐ Renal disease
- ☐ Transplant recipient
- ☐ Other: ________________________________

If the patient is female, what is her pregnancy status?

- ☐ Not pregnant
- ☐ Currently pregnant
- ☐ Not pregnant but nursing
- ☐ Unknown

Case Definition

☐ **Suspect Case** ☐ **Probable Case** ☐ **Confirmed Case**

Suspect Case: Exposure to water or to seafood with a confirmed algal bloom AND onset of associated signs and symptoms within a reasonable time after exposure AND without identification of another cause of illness.

Probable Case: Meets criteria for Suspect Case AND there is a laboratory documentation of a HAB toxin(s) in the water.

Confirmed Case: Meets criteria for a Probable Case combined with professional judgment based on medical review.