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

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? ☐Y ☐N ☐U Notes:
Was species of Vibrio confirmed at the State Laboratory of Public Health? ☐Y ☐N ☐U

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? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐Y ☐N ☐U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy):_____
Dehydration ☐Y ☐N ☐U
Signs of dehydration (choose all that apply):
☐ Decreased skin turgor
☐ Dry mucous membranes
☐ Non-palpable pulse
☐ Sunken eyes
☐ Decreased urine output
Shock ☐Y ☐N ☐U
Was systolic BP <90mm Hg ☐Y ☐N ☐U
Was shock septic? ☐Y ☐N ☐U
Headache ☐Y ☐N ☐U
Muscle aches / pains (myalgias) ☐Y ☐N ☐U
Skin lesions ☐Y ☐N ☐U
Please describe (check all that apply)
☐ Bullae Where? _____
Cellulitis ☐Y ☐N ☐U
Where? _____
Nausea ☐Y ☐N ☐U
Vomiting ☐Y ☐N ☐U
Abdominal pain or cramps ☐Y ☐N ☐U
Is there visible blood in the stool? ☐Y ☐N ☐U
Melena (tarry stools) ☐Y ☐N ☐U

Diarrhea ☐Y ☐N ☐U
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 ☐Y ☐N ☐U
Specify:

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

P	N	I	O	NT	
☐	☐	☐	☐	☐	**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 ☐ Unkown
☐	☐	☐	☐	☐	**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? ☐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
List persons and contact information:
_____
_____
_____
Additional travel information: _____
_____
_____
Notes:

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						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
- ☐ Intentional ingestion
- ☐ Skin contact
- ☐ Inhalation
- ☐ 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

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.