North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

VIBRIO INFECTION OTHER THAN CHOLERA & VULNIFICUS

Confidential Communicable Disease Report—Part 2

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

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__________
Unit:
☐ Fahrenheit ☐ Centigrade
Fever onset date (mm/dd/yyyy):__________
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 rash ☐Y ☐N ☐U
Skin lesions ☐Y ☐N ☐U
Please describe (check all that apply)
☐ Papule ☐ Ulcer ☐ Bullae
Cellulitis ☐Y ☐N ☐U
Nausea ☐Y ☐N ☐U
Vomiting ☐Y ☐N ☐U
Abdominal pain or cramps ☐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
Please specify:

PREDISPOSING CONDITIONS

HIV/AIDS ☐Y ☐N ☐U
Immunosuppressive conditions (other than HIV/AIDS) ☐Y ☐N ☐U
Diabetes ☐Y ☐N ☐U
Is the patient on insulin? ☐Y ☐N ☐U
Hematologic disorder ☐Y ☐N ☐U
Sickle cell ☐Y ☐N ☐U
Other hematologic disorder(s) ☐Y ☐N ☐U
Malignancy ☐Y ☐N ☐U
Cardiovascular/heart disease ☐Y ☐N ☐U
Gastrointestinal disease ☐Y ☐N ☐U
☐ Gastric surgery or gastrectomy
☐ Peptic ulcer
☐ Other GI disease (GERD, etc.)
Specify:

Liver disease ☐Y ☐N ☐U
☐ Chronic liver disease or cirrhosis
☐ Liver failure
☐ Other liver disease(s)
Kidney disease ☐Y ☐N ☐U
☐ Chronic renal failure
☐ Acute renal failure
☐ Other kidney disease(s)
Injury/Wound/Break in skin ☐Y ☐N ☐U
Anatomic site__________
Other condition potentially affecting skin integrity? ☐Y ☐N ☐U
Specify condition(s)__________
Receiving treatment or taking any medications ☐Y ☐N ☐U
☐ Antacids
☐ Antibiotics
☐ Chemotherapy
☐ H2 blockers, proton pump or ulcer medication
☐ Immunosuppressive therapy, including anti-rejection therapy
☐ Radiotherapy
☐ Systemic steroids/corticosteroids, including steroids taken by mouth or injection

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

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):____/____/____

Patient's Last Name	First	Middle	Maiden/Other	Suffix	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

TREATMENT

Did the patient take an antibiotic as treatment for this illness?............................... ☐ Y ☐ N ☐ U

Specify antibiotic name _______________________

TRAVEL/IMMIGRATION

The patient is:

- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ Foreign Visitor
- ☐ Refugee
- ☐ Recent Immigrant
- ☐ Foreign Adoptee
- ☐ None of the above

Did patient travel during the 24 hours 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/residency information:

WATER EXPOSURE

During the 24 hours prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to estuarine or marine water (brackish or salt water sound, estuary, ocean) ? .... ☐ Y ☐ N ☐ U

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
- ☐ Skin contact
- ☐ Inhalation
- ☐ Other
- ☐ Unknown

Water source(s) / setting(s) (select all sources and settings that apply):

- ☐ River, stream (brackish only)
- ☐ Estuary / tidal area (brackish / salty water)
- ☐ Ocean
- ☐ Pool (salt water or brackish only)
- ☐ Whirlpool / spa pool (salt water or brackish only)
- ☐ Other
- ☐ Unknown

FOOD EXPOSURE

During the 24 hours prior to onset of symptoms, did the patient do any of the following:

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

Does the patient have a water softener or water filter installed inside the house to treat their water? .... ☐ Y ☐ N ☐ U

During the 24 hours 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

Handle / eat clams?.......................... ☐ Y ☐ N ☐ U

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

Was seafood 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__________________________

____

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 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

Notes:

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						SSN

OTHER EXPOSURE INFORMATION

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 ___________________________________

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: