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

CYCLOSPORIASIS

Confidential Communicable Disease Report—Part 2

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

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.

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): ____/____/____

Fatigue or malaise or weakness ☐Y ☐N ☐U
Loss of appetite ☐Y ☐N ☐U
Weight loss with illness ☐Y ☐N ☐U
Muscle aches/pains (myalgias) ☐Y ☐N ☐U
Nausea ☐Y ☐N ☐U
Vomiting ☐Y ☐N ☐U
Bloating or gas ☐Y ☐N ☐U
Abdominal pain or cramps ☐Y ☐N ☐U
Constipation ☐Y ☐N ☐U
Diarrhea ☐Y ☐N ☐U
- Describe (select all that apply)
- ☐ Bloody ☐ Watery
- ☐ Non-bloody ☐ 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

Any immunosuppressive conditions ☐Y ☐N ☐U
Please specify: ____________________________

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, specify____________________________
- ☐ Unknown

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

Did local health director or designee implement additional control measures? ☐Y ☐N
If yes, specify: ____________________________
____

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):_____/_____/_____

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident of North Carolina
- ☐ Resident of another state or US territory
- ☐ None of the above

Did patient have a travel history during the 14 days prior to onset of symptoms? ☐Y ☐N ☐U
Travel dates: From:____________until ____________
To city:____________________________
To country:____________________________
Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐Y ☐N ☐U
Name: ____________________________
Additional travel/residency information:

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

BEHAVIORAL RISK & CONGREGATE LIVING

During the 14 days prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/ fraternity)**?** ☐ Y ☐ N ☐ U

Name of facility: ____________

Dates of contact: ____________

During the 14 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? ☐ Y ☐ N ☐ U

If yes, specify: ____________

In what setting was the patient most likely exposed?

- ☐ Restaurant
- ☐ Home
- ☐ Work
- ☐ Child Care
- ☐ School
- ☐ University/College
- ☐ Camp
- ☐ Doctor's office/ Outpatient clinic
- ☐ Hospital In-patient
- ☐ Hospital Emergency Department
- ☐ Laboratory
- ☐ Long-term care facility /Rest Home
- ☐ Military
- ☐ Prison/Jail/Detention Center
- ☐ Place of Worship
- ☐ Outdoors, including woods or wilderness
- ☐ Athletics
- ☐ Farm
- ☐ Pool or spa
- ☐ Pond, lake, river or other body of water
- ☐ Hotel / motel
- ☐ Social gathering, other than listed above
- ☐ Travel conveyance (airplane, ship, etc.)
- ☐ International
- ☐ Community
- ☐ Other (specify) ____________
- ☐ Unknown

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐ Y ☐ N ☐ U

If yes, specify:

FOOD RISK AND EXPOSURE

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 14 days prior to onset of symptoms, did the patient drink any bottled water? ☐ Y ☐ N ☐ U

Specify type/brand ____________

Where does the patient/patient's family typically buy groceries?

Store name: ____________

Store city: ____________

Shopping center name/address: ____________

During the 14 days prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? ☐ Y ☐ N ☐ U

Specify source: ____________

Eat any food items that came from a store or vendor where they do not typically shop for groceries? ☐ Y ☐ N ☐ U

Specify source(s): ____________

FOOD RISK AND EXPOSURE (continued)

During the 14 days prior to onset of symptoms, did the patient:

Drink unpasteurized milk? ☐ Y ☐ N ☐ U

Specify type of milk:
- ☐ Cow
- ☐ Goat
- ☐ Sheep
- ☐ Other, specify: ____________
- ☐ Unknown

Drink unpasteurized juices or ciders? ☐ Y ☐ N ☐ U

Specify juices or ciders:
- ☐ Apple
- ☐ Orange
- ☐ Other, specify: ____________

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)**?** ☐ Y ☐ N ☐ U

- Handle/eat clams? ☐ Y ☐ N ☐ U
- Handle/eat crabs? ☐ Y ☐ N ☐ U
- Handle/eat lobster? ☐ Y ☐ N ☐ U
- Handle/eat mussels? ☐ Y ☐ N ☐ U
- Handle/eat oysters? ☐ Y ☐ N ☐ U
- Handle/eat shrimp? ☐ Y ☐ N ☐ U
- Handle/eat crawfish? ☐ Y ☐ N ☐ U
- Handle/eat other shellfish? ☐ Y ☐ N ☐ U

Eat raw fruit? ☐ Y ☐ N ☐ U

Specify raw fruit:
- ☐ Apples
- ☐ Bananas
- ☐ Oranges
- ☐ Grapes, specify: ____________
- ☐ Pears
- ☐ Peaches
- ☐ Berries, specify ____________
- ☐ Melon, specify ____________
- ☐ Mangoes
- ☐ Other, specify: ____________

Eat raw salads or vegetables other than sprouts? ☐ Y ☐ N ☐ U

Specify raw salad or vegetable:
- ☐ Bagged salad greens without toppings, type: ____________
- ☐ Salad with toppings, specify: ____________
- ☐ Lettuce, type: ____________
- ☐ Spinach
- ☐ Tomatoes, type: ____________
- ☐ Cucumbers
- ☐ Mushrooms, type: ____________
- ☐ Onions, type: ____________
- ☐ Potatoes, type: ____________
- ☐ Other, specify: ____________

Eat sprouts? ☐ Y ☐ N ☐ U

Specify type of sprouts:
- ☐ Alfalfa ☐ Clover ☐ Bean
- ☐ Other, specify: ____________
- ☐ Unknown

Eat fresh herbs? ☐ Y ☐ N ☐ U

Specify:
- ☐ Basil
- ☐ Parsley
- ☐ Oregano
- ☐ Cumin
- ☐ Other, specify: ____________
- ☐ Thyme
- ☐ Cilantro
- ☐ Rosemary

Eat at a group meal? ☐ Y ☐ N ☐ U

Specify:
- ☐ Place of Worship
- ☐ School
- ☐ Social function
- ☐ Other, Specify: ____________

Eat food from a restaurant? ☐ Y ☐ N ☐ U

Name: ____________

Location: ____________

WATER EXPOSURE

During the 14 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

If yes, describe in detail giving type of activity, water, route of exposure, water sources, factors contributing to water contamination, and any water treament methods:

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 regarding setting of exposure: