

GIARDIASIS INVESTIGATION FORM

BASIC DEMOGRAPHIC DATA

Last Name: _____ First Name: _____ Middle Name: _____

DOB: ___/___/____ Age: _____ years months Current Sex: Female Male Unknown

Marital Status: Married Single, never married Widowed Annulled Divorced Domestic partner Interlocutory Legally separated
 Polygamous Refused to answer Unknown

Is the patient deceased? No Unknown Yes Date of Death: ___/___/____

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: (____) - ____ - _____ Cell Phone: (____) - ____ - _____ Work Phone: (____) - ____ - _____ Ext. _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Other Pacific Islander White Unknown

INVESTIGATION SUMMARY

Investigation Start Date: ___/___/____ Investigation Status: Open Closed Investigator: _____

REPORTING SOURCE

Date of Report: ___/___/____ Reporting Source: _____

CLINICAL

Physician's Name: _____ Phone Number: (____) - ____ - _____ Ext. _____

Was patient hospitalized for this illness? No Unknown Yes If yes: Hospital Name: _____

Admission Date: ___/___/____ Discharge Date: ___/___/____ Duration of Stay _____ day(s)

Diagnosis Date: ___/___/____ Illness Onset Date: ___/___/____ Illness End Date: ___/___/____

Age at Onset: _____ days hours minutes months unknown weeks years

Did the patient die from this illness? No Unknown Yes Date of Death: ___/___/____

EPIDEMIOLOGIC

Is this patient associated with a day care facility? No Unknown Yes Is this patient a food handler? No Unknown Yes

Is this case part of an outbreak? No Unknown Yes If yes, outbreak name: _____

Case Status: Confirmed Not a Case Probable Suspect Unknown MMWR Week: _____ MMWR Year: _____

ADMINISTRATIVE

General Comments: _____

PHA4 SUPERVISOR REVIEW

Date Due: ___/___/____ Investigation ready for supervisor review: Reviewed (Complete) Reviewed (Incomplete)

Date investigation ready for supervisor review: ___/___/____ Reviewed (Not a case) Yes

Review comments (completed by supervisor): _____

SIGNS AND SYMPTOMS

Diarrhea: No Unknown Yes Bloating: No Unknown Yes Weight Loss: No Unknown Yes
Abdominal cramps: No Unknown Yes Malabsorption: No Unknown Yes

DAY CARE

Attend a day care center? No Unknown Yes Work at a day care center? No Unknown Yes
Live with a day care center attendee? No Unknown Yes What is the name of the day care facility? _____
What type of day care facility: Adult day health care Adult day social care Alzheimer's specific day care
 Child care center Child care provided by friend, relative, neighbor In-home care giver
Is food prepared at this facility? No Unknown Yes Does this facility care for diapered persons? No Unknown Yes

FOOD HANDLER

Did the patient work as a food handler after onset of illness? No Unknown Yes
What was the last date worked as a food handler after onset of illness? ___/___/____
Where was the patient a food handler? _____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? No Unknown Yes Applicable incubation period for this illness is: **3-25 days**
What was the purpose of travel? Business Migration (immigration to US) Other _____ Tourism Visiting relatives/friends
Please specify the destination(s):
Destination 1 Type: Domestic State/Territory: _____ International Country: _____
Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: ___/___/____ Departure Date: ___/___/____
Destination 2 Type: Domestic State/Territory: _____ International Country: _____
Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: ___/___/____ Departure Date: ___/___/____
Destination 3 Type: Domestic State/Territory: _____ International Country: _____
Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: ___/___/____ Departure Date: ___/___/____
If more than 3 destinations, specify details here: _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? Do not use tap water Municipal, city, or county Other _____ Private well Unknown

If "Private Well", how was home well water treated?

Both filtered and disinfected Disinfected Filtered Neither filtered nor disinfected Unknown

What is the source of tap water at school/work? Do not use tap water Municipal, city, or county Other _____ Private well Unknown

If "Private Well", how was school/work well water treated?

Both filtered and disinfected Disinfected Filtered Neither filtered nor disinfected Unknown

Did the patient drink untreated water in the **3-25 days** prior to onset of illness (e.g., from a river while camping)? No Unknown Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **3-25 days** prior to illness? No Unknown Yes

What was the recreational water exposure type? (select all that apply)

Hot Spring Hot Tub-Whirlpool-Jacuzzi-Spa Interactive Fountain Lake-Pond-River-Stream
 Ocean Other _____ Recreational Water Park Swimming Pool

If "Swimming Pool", please specify swimming pool type:

Camp Pool Hospital/Therapy Pool Hotel/Motel/Resort Vacation Pool
 Kiddie/Wading Pool Municipal/Community Pool Neighborhood/subdivision/Apartment/Condo Pool
 Other, specify _____ Private Club/Membership Pool Private Home Pool, not a kiddie/wading pool
 School/College/University Pool Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal in the **3-25 days** prior to onset of illness? No Unknown Yes

If yes, select type of animal: Cat Cattle Chicken Dog Goats Lizard
 Poultry Rodent Sheep Swine Turtle Unknown
 Other, specify: _____

Name or location of animal contact: _____

Did a patient come into contact with animal food/feed(s) in the **3-25 days** prior to onset of illness? No Unknown Yes

If yes, select associated animal food/feed(s): Cat Cattle Chicken Dog Goats Lizard
 Poultry Rodent Sheep Swine Turtle Unknown
 Other, specify: _____

If applicable, please list food brand(s): _____

SEAFOOD EXPOSURE

Has the patient eaten seafood in the last 14 days? No Unknown Yes

Was the seafood eaten undercooked? No Unknown Yes

Was the seafood eaten raw? No Unknown Yes

If yes, type of raw seafood: Clams Crab Crawfish Fish Lobster
 Mussel Oysters Shrimp
 Other fish, specify: _____
 Other shellfish, specify: _____

Where was the seafood obtained? Food store oyster bar or restaurant seafood market Truck or roadside vendor
 Unknown Other, specify: _____

Date raw seafood consumed: ___/___/_____

Time raw seafood consumed: ___:___ AM PM

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

- | | | |
|---|---|---|
| <input type="checkbox"/> CSF leak | <input type="checkbox"/> Hodgkin's disease | <input type="checkbox"/> IVDU |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Asthma | <input type="checkbox"/> Atherosclerotic cardiovascular disease (ASCVD)/CAD |
| <input type="checkbox"/> Burns | <input type="checkbox"/> Cerebral vascular accident (CVA) stroke | <input type="checkbox"/> Chronic GI illness/diarrhea |
| <input type="checkbox"/> Cirrhosis/liver failure | <input type="checkbox"/> Cochlear implant | <input type="checkbox"/> Current smoker |
| <input type="checkbox"/> Deaf/profound hearing loss | <input type="checkbox"/> Diabetes mellitus (insulin): <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Yes | <input type="checkbox"/> Emphysema/COPD |
| <input type="checkbox"/> Gastric surgery (type): _____ | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Hematologic disease (type): _____ |
| <input type="checkbox"/> Immunodeficiency (type): _____ | <input type="checkbox"/> Immunoglobulin deficiency | <input type="checkbox"/> Immunosuppressive therapy (steroids, chemotherapy) |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Multiple myeloma | <input type="checkbox"/> Nephrotic Syndrome |
| <input type="checkbox"/> None | <input type="checkbox"/> Organ transplant (organ): _____ | <input type="checkbox"/> Other liver disease (type): _____ |
| <input type="checkbox"/> Other malignancy (type): _____ | <input type="checkbox"/> Other prior illness (type): _____ | <input type="checkbox"/> Other renal disease (type): _____ |
| <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Renal failure/dialysis | <input type="checkbox"/> Sickle cell anemia |
| <input type="checkbox"/> Splenectomy/asplenia | <input type="checkbox"/> Systemic lupus erythematosus (SLE) | <input type="checkbox"/> Unknown |

RELATED CASES

Does the patient know of any similarly ill persons? No Unknown Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: No Unknown Yes

Are the other cases related to this one? No, sporadic Unknown Yes, household Yes, not household Yes, outbreak

Note: Please enter name and Case ID of epi-linked case(s) in the General Comments section of the NEDSS Investigation.