Giardia Case Report Worksheet

Name: _____ **CDRSS Number:** _____

Interviewer: _____ **Date Completed**: _____

Information provided by _____ **Relation to Case:** _____

DEMOGRAPHICS

Gender: ☐ Male ☐ Female

Date of Birth ____/____/_____

Hispanic: ☐ Yes ☐ No ☐ Unk

Race:

☐ White ☐ Native Amer.

☐ Black ☐ Asian/Pac. Islander

☐ Other ☐ Unknown

Occupation/Setting:

Daycare worker/attendee: ☐ Yes ☐ No

Healthcare provider: ☐ Yes ☐ No

Foodhandler: ☐ Yes ☐ No

Group Living: ☐ Yes ☐ No

Attend or work in a school/camp: ☐ Yes ☐ No

If yes to any above, did patient work/attend while ill? ☐ Yes ☐ No

If the case is a food handler, health care worker or works for or attends a daycare, obtain details about site, job description, dates worked/attended during communicable period. For exclusion guidance see recommendations in the NJDOH disease chapter.

CLINICAL INFORMATION

Symptomatic: ☐ Yes ☐ No

If yes: Onset date/time: ____/_____/_____ _____

Resolution date/time: ____/_____/_____ _____

First/predominant symptom_____

Abdominal pain/cramps:	☐ Yes ☐ No onset date/time:
Abnormal stools (fatty):	☐ Yes ☐ No onset date/time:
Bloating/Gas:	☐ Yes ☐ No onset date/time:
Diarrhea:	☐ Yes ☐ No onset date/time:
Fatigue:	☐ Yes ☐ No onset date/time:
Nausea:	☐ Yes ☐ No onset date/time:
Vomiting:	☐ Yes ☐ No onset date/time:
Weight loss:	☐ Yes ☐ No onset date/time:

Other symptoms:

_____

_____

_____

Physician Name: _____

Physician Phone: _____

Antibiotic treatment: ☐ **Yes** ☐ **No**

If yes, dates taken:

____/____/_____ to ____/____/_____

Hospitalized: ☐ **Yes** ☐ **No**

Name of Hospital_____

Date of Admission: _____/_____/_____

Date of Discharge: _____/_____/_____

ED visit only-date: _____/_____/_____

Outcome: Died: ☐ **Yes** ☐ **No**

If yes, date of death: _____/_____/_____

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Y N

☐ ☐ Travel outside the U.S. 10-14 days prior to symptom onset

Where: _____

Dates: ____/____/___ to ____/____/_____

Y N

☐ ☐ Travel within the U.S. 10-14 days prior to symptom onset

Where: _____

Dates: ____/____/___ to ____/____/_____

EXPOSURE SOURCES (use 10-14 days prior to symptom onset):

Y N

☐ ☐ **Recreational water exposures**

If yes, specify type: ☐ Natural freshwater (i.e. lake) ☐ Natural saltwater (i.e. ocean) ☐ Pool/spa ☐ Water park/fountains

Details including date: _____

_____

Did person Touch water? Y/N Wade? Y/N Swim? Y/N Accidentally or intentionally swallow water?

☐ ☐ **Hiking/Camping/Backpacking**

If yes: Location _____

Did person drink river or stream water?

If yes: Was water treated or filtered? Check all methods that apply ☐ Boiled ☐ Filtered ☐ Chemically treated

☐ ☐ **Contact with wild animals**

Location: _____ Animals encountered: _____

☐ ☐ **Contact with pets**

Animals encountered: ☐ Puppies ☐ Kittens ☐ Dogs ☐ Cats ☐ Birds ☐ Fish ☐ Reptiles

☐ Other (please specify) _____

☐ ☐ **Visit/Work with farm, dairy, zoo animals**

Animals encountered: ☐ Cows ☐ Horses ☐ Goats ☐ Pigs ☐ Sheep ☐ Birds ☐ Fowl ☐ Exotics

☐ Other (please specify) _____

Ask if individual consumed the following foods or performed the following actions WITHIN THE PAST 10-14 DAYS.

Y N U

☐ ☐ ☐ **Consumed fresh fruit or vegetables. If yes, were they washed in tap water from house?** ☐ Yes ☐ No

☐ ☐ ☐ **Consumed raw or undercooked meat. If yes, was any wild game (e.g. deer, wild turkey, rabbit)?** ☐ Yes ☐ No

☐ ☐ ☐ **Consumed any other raw, uncooked, or unpasteurized foods (including homemade ice cream)**

If yes to any of above, was any food eaten in a restaurant? ☐ Yes ☐ No If yes, please specify:

Name: _____ Location: _____ Date: _____

Name: _____ Location: _____ Date: _____

Name: _____ Location: _____ Date: _____

☐ ☐ ☐ **Consumed food sample at store**

☐ ☐ ☐ **Ate a group meal (potluck, reception, etc.)**

☐ ☐ ☐ **Water source known**

☐ Individual well ☐ Shared well ☐ Public water ☐ Bottled water ☐ Other_____

If well: How far from septic system is well located? _____ Depth of well? _____

Recently drilled? ☐ Yes ☐ Is well water tested? ☐ Yes ☐ Is well water treated? ☐ Yes ☐

☐ ☐ ☐ **Consumed filtered water?**

If yes: ☐ Filter on faucet (e.g. Brita) ☐ Filter on pitcher for drinking water ☐ Whole house filter system

Does the case know anyone with a similar illness, including those he/she lives with? ☐ **YES** ☐ **NO**

If yes, fill out table below for each ill household member and contact.

ILL HOUSEHOLD MEMBERS/ OTHER ILL CONTACTS

Name	**Age**	**Relation to case**	**Symptoms**	**Onset date**	**Phone Number**
_____	_____	_____	_____	____/____/____	_____
_____	_____	_____	_____	____/____/____	_____
_____	_____	_____	_____	____/____/____	_____

If the case or contact is a food handler, health care worker or works for or attends a daycare, provide details about site, job description, dates worked/attended during communicable period. For exclusion guidance see recommendations in the NJDOH disease chapter.

_____

_____

_____

_____

ACTIONS TAKEN

☐ Interviewed w/worksheet

☐ Patient could not be interviewed (reason):

_____

Dates interview attempted

☐_____☐_____ ☐_____

☐ Spoke to healthcare provider

☐ Daycare inspection/education

☐ Follow-up of ill contacts

☐ Refer for restaurant inspection

☐ Work or daycare restriction for case

☐ Entered into CDRSS