Cryptosporidiosis Investigation Checklist for Local Health Departments

Local health department staff should follow these steps, not necessarily always in order, when investigating reports of cryptosporidiosis. For more detailed information refer to the Cryptosporidiosis Disease Chapter. Cryptosporidiosis is a Priority Level 4 disease and critical details should be entered into the Communicable Disease Reporting and Surveillance System (CDRSS) within 14 days.

- ☐ Review laboratory details to confirm the test result. If the case has not been submitted via CDRSS, create a case.
- ☐ Interview the case-patient (parent/guardian if case-patient is a minor) via phone using the "Cryptosporidiosis Case Report Form". Do not fax the form to the physician or mail to the home of the case-patient for completion.
- ☐ Provide education to the case-patient; additional information can be found on the NJDOH and CDC disease pages.
- ☐ Enter critical details (demographics, signs/symptoms, clinical status, additional laboratory information, and industry/occupation) into the CDRSS case.
- ☐ Enter relevant exposures (travel, food history, restaurants, yardwork, contact with recreational water, pets, livestock, or animals) into the *Sources of Infection and Risk Factors* section within the CDRSS case.
- ☐ Notify the appropriate local health department and document in CDRSS if a food establishment, restaurant, etc. from another jurisdiction is identified as a possible source of exposure.
- ☐ Inform the Foodborne and Waterborne Disease Unit at cds.fwd.epi@doh.nj.gov if an outbreak is suspected.
- ☐ Enter any additional symptomatic contacts identified through the interview into the *Contact Tracing* section within CDRSS and follow case investigation as appropriate.
- ☐ Document dates/times of at least three attempts made to reach the case-patient in CDRSS if they remain unreachable.
- ☐ Determine *Case Status* based on NNDSS case definitions and mark *Report Status* as "LHD CLOSED" in CDRSS.

Cryptosporidiosis 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_____

Diarrhea (3 loose stools/24 hrs.):	☐ Yes ☐ No onset date/time:
Diarrhea lasting ≥ 72 hours	☐ Yes ☐ No onset date/time:
Abdominal pain/cramps:	☐ Yes ☐ No onset date/time:
Nausea:	☐ Yes ☐ No onset date/time:
Vomiting:	☐ Yes ☐ No onset date/time:
Fever:	☐ Yes ☐ No onset date/time:
Headache:	☐ Yes ☐ No onset date/time:
Loss of appetite:	☐ Yes ☐ No onset date/time:

Other symptoms:

_____

_____

_____

Physician Name: _____

Physician Phone: _____

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

If yes, name of antibiotic and 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. 2 weeks prior to symptom onset

Where: _____

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

Y N

☐ ☐ Travel within the U.S. 2 weeks prior to symptom onset

Where: _____

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

EXPOSURE SOURCES (use 2 weeks prior to symptom onset): Date Range: _____to_____

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? ☐ Yes ☐ No Wade? ☐ Yes ☐ No Swim? ☐ Yes ☐ No

Accidentally or intentionally swallow water? ☐ Yes ☐ No ☐ Unknown

☐ ☐ **Hiking/Camping/Backpacking?**

If yes: Location _____

Did person drink river or stream water? ☐ Yes ☐ No

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

☐ ☐ **Yardwork/composting (w/manure and/or fertilizer)?**

☐ ☐ **Contact with any animals (including farm animals and pets)?**

Animals encountered: ☐ Puppies ☐ Kittens ☐ Dogs ☐ Cats ☐ Other *(specify)* _____

☐ ☐ **Visit/Work on a farm, petting zoo, county/state fair, rodeo, dairy?**

Animals encountered: *(specify)* _____

☐ ☐ **Contact with animal waste/manure?**

☐ Cat ☐ Dog ☐ Farm animal ☐ Other *(specify)* _____

If yes, were any animals sick with diarrhea? ☐ Yes ☐ No ☐ Unknown

Details of exposure _____

Ask if individual consumed the following foods or performed the following actions WITHIN THE PAST 2 WEEKS.

Y N U

☐ ☐ ☐ **Consumed raw or unpasteurized milk?**

Was milk unrefrigerated for >1 hour, including during transport? ☐ Yes ☐ No ☐ Unknown

☐ ☐ ☐ **Other unpasteurized milk products (cheese, cream, ice cream?)** _____

☐ ☐ ☐ **Unpasteurized juice or cider?** _____

☐ ☐ ☐ **Raw fruits or vegetables (store bought/home grown)?** *(specify)*_____

If yes: Date(s) of consumption: _____

If yes to any of above, was any food eaten in a restaurant? ☐ Yes ☐ No If yes, provide restaurant name and location

Name: _____ Location: _____ Date: _____

Name: _____ Location: _____ Date: _____

Name: _____ Location: _____ Date: _____

☐ ☐ ☐ **Water source?**

☐ 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 No ☐ Is well water tested? ☐ Yes No ☐ Is well water treated? ☐ Yes No ☐

☐ ☐ ☐ **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, healthcare 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

☐ Patient education