NJ Health
New Jersey Department of Health
Communicable Disease Service

Giardiasis Investigation Checklist for Local Health Departments

Local health department staff should follow these steps, not necessarily always in order, when investigating reports of giardiasis. For more detailed information refer to the Giardiasis Disease Chapter. Giardiasis 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 "Giardiasis 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, contact with recreational water, restaurants, 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.

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___________________________

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