Giardiasis

ORPHEUS

☐ confirmed
☐ presumptive
☐ suspect
☐ no case

Name _____ COUNTY _____
LAST, first,initials (a.k.a.)

Address _____
Street City Zip

Phone number _____/ _____ special housing _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

ALTERNATIVE CONTACT
Name _____ Phone(s) _____
LAST, first,initials home (H), work (W), cell (C), message (M)

DEMOGRAPHICS

DOB ____/____/____
m d y

if DOB unknown, AGE _____

SEX ☐ Female ☐ Male

LANGUAGE _____

COUNTRY OF BIRTH_____

worksites/school/day care center
_____

Occupation/grade _____

RACE (*check all that apply*)

☐ White
☐ Black
☐ Asian
☐ Pacific Islander
☐ American Indian/Alaska Native
☐ unknown
☐ other_____

HISPANIC ☐ Y ☐ N
☐ Unknown ☐ Declined

PROVIDERS, FACILITIES AND LABS

Reporter (circle one) Type

☐_____
name and phone number

PMD Lab-fax
MDx Lab-phone
ER Lab-other
ICP HCP
Lab-ELR

Reporter (circle one) Type

☐_____
name and phone number

PMD Lab-fax
MDx Lab-phone
ER Lab-other
ICP HCP
Lab-ELR

☐ Ok to contact patient (only list once)

Local epi_name_____

Date report received by LHD ____/____/____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic ☐ yes ☐ no ☐ unk
if yes, ONSET on ____/____/____
diagnosis date ____/____/____

diarrhea	☐ yes	☐ no	☐ unk
cramps	☐ yes	☐ no	☐ unk
nausea	☐ yes	☐ no	☐ unk
vomiting	☐ yes	☐ no	☐ unk
loss of appetite	☐ yes	☐ no	☐ unk
weight loss	☐ yes	☐ no	☐ unk

fever highest temp _____

Deceased ☐ yes ☐ no date of death ____/____/____
Cause: _____

Hospitalized: ☐ yes ☐ no ☐ unk
Name _____
Chart number_____
Admit date ____/____/____ ☐ ICU
Discharge date ____/____/____
Status: Check one:
☐ alive ☐ dead ☐ unknown ☐ transfer

Name _____
Chart number_____
Admit date ____/____/____ ☐ ICU
Discharge date ____/____/____
Status: Check one:
☐ alive ☐ dead ☐ unknown ☐ transfer

LABORATORY DATA

Testing Lab _____

Originating Lab _____

Collection date ____/____/____

Specimen tyoe:
☐ stool ☐ serum
☐ other_____

Test Type	pos	neg
Antigen	☐	☐
Culture	☐	☐
DFA/IFA	☐	☐
Antibody	☐	☐
Immunostat card	☐	☐

O & P ☐ cysts ☐ trophs ☐

Treatment

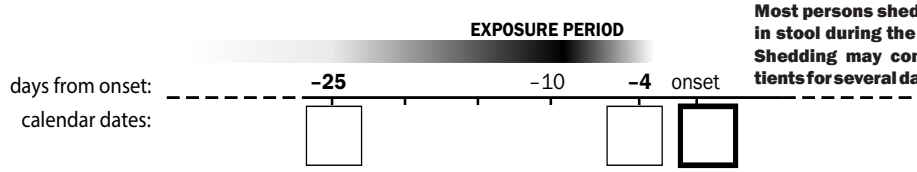
Drug name	size/dose/frequency	start date	end date
Furazolidone (Furoxene)		____/____/____	____/____/____
Metroidazole (Fkagyl)		____/____/____	____/____/____
Paramomycin		____/____/____	____/____/____
Quinacrine hydrochloride (Atabrine)		____/____/____	____/____/____

Comments:

CASE'S NAME

INFECTION TIMELINE

Enter onset date in heavy box. Count back to figure the probable exposure period.



Most persons shed infectious oocysts in stool during the period of diarrhea. Shedding may continue in some patients for several days—possibly longer.

Interviewed ☐ yes ☐ no Interview date(s) ____/____/____ ____/____/____

Who ☐ patient ☐provider ☐ parent ☐ other_____

by who _____

Reason not interviewed (choose one)
- ☐ not indicated
- ☐ unable to reach
- ☐ out of jursdiction
- ☐ deceased
- ☐ refused
- ☐ medical record review
- ☐ physician interview

RISKS Provide details as appropriate.

yes	no	refused	unk	
☐	☐	☐	☐	travel outside U.S. to (specify place, reason, transportation mode (car) travel companions
☐	☐	☐	☐	drink untreated surface water
☐	☐	☐	☐	attend, visit or work at organized child care center
☐	☐	☐	☐	contact with diapered or incontinent people
☐	☐	☐	☐	male homosexual contact
☐	☐	☐	☐	contact with people sick with acute gastroenteritis
☐	☐	☐	☐	swimming, wading, spashing or boating
☐	☐	☐	☐	contact with livestock
☐	☐	☐	☐	contact with farm animals
☐	☐	☐	☐	contact with pets sick with loose stools
☐	☐	☐	☐	recent arrival from overseas (specify)
☐	☐	☐	☐	eating at restaurants
☐	☐	☐	☐	eat at public gatherings (potlucks, events)
☐	☐	☐	☐	other water-related exposures _____

SOURCE OF HOME WATER
- ☐ private well water
- ☐ private surface water
- ☐ public/community system
  name of company:_____
- ☐ bottled water
- ☐ unknown
- ☐ other specify_____

OTHER FOLLOW-UP. Provide details as appropriate.

yes	no	refused	unk	
☐	☐	☐	☐	does the case know anyone with a similar illness
☐	☐	☐	☐	did the case prepare food for public/private gathering
☐	☐	☐	☐	household members work in food service
☐	☐	☐	☐	household members health care workers
☐	☐	☐	☐	household members work in day care
☐	☐	☐	☐	case work or atend day care
☐	☐	☐	☐	case educated how to reduce disease transmission
☐	☐	☐	☐	work or daycare restriction for case
☐	☐	☐	☐	daycare inspected
☐	☐	☐	☐	restaurant inspection

EPI-LINKAGE

Associated with a known outbreak? ☐ yes ☐ no ☐ unk

Close contact of another case ☐ yes ☐ no ☐ unk

Specify nature of contact

☐co-worker ☐ daycare ☐ friend ☐ household ☐ sexual

Has the above case been reported? ☐ yes ☐ no ☐ unk

If yes to any question, specfiy names, dates, places.

CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER

Name	DOB/Age	Sex	Relation to case	Occupation	Education provided	Last exposure	Onset date	Interview date	Sick
		☐ M ☐ F	☐ daycare ☐ friend ☐ household ☐ sexual			____/____/____	____/____/____	____/____/____	☐ Y ☐N
		☐ M ☐ F	☐ daycare ☐ friend ☐ household ☐ sexual			____/____/____	____/____/____	____/____/____	☐ Y ☐N
		☐ M ☐ F	☐ daycare ☐ friend ☐ household ☐ sexual			____/____/____	____/____/____	____/____/____	☐ Y ☐N

ADMINISTRATION

Orpheus October 2014

Remember to copy patient's name to the top of this page.

Case report sent to OHA on ____/____/____

Completed by _____ Date _____ Phone _____

Investigation sent to OHA on ____/____/____