Foodborne Diseases Active Surveillance Network (FoodNet) Case Report Parasitic Form

Local Case ID (Medical Record #): _____ **Isolated Parasite:** _____

Patient's name: _____
Last First

Address: _____ **Phone No**: ( ) _____ - _____
Number/ Street City State ZIP

PHLIS ID # (Patient-Specimen): □□□□□□□□-□□□□□□□□□□-□□□-□□
Site ID **Patient ID** **Spec ID** **Aliquot ID**

Local ID: _____-□□□□

NEDSS ID: PSN1-□□□□□□-□□-□□ **CAS1**-□□□□□□□-□□-□□
Patient ID **State** **Installation** **Investigation ID** **State** **Installation**

1) COUNTY (residence of patient):

_____
_____

2) SEX:

☐ Male ☐ Female ☐ Unknown

3) DATE OF BIRTH:

_____ /_____ /_____
month day year

4) RACE: (original categories)

☐ **White**
☐ **Black**
☐ **American Indian/ Native Alaskan**
☐ **Unknown**
☐ **Asian or Pacific Islander**

4a) RACE: (additional FN categories)

☐ Asian
☐ Pacific Islander or Native Hawaiian
☐ Multi-racial
☐ Other

5) ETHNICITY:

☐ Hispanic
☐ Non-Hispanic
☐ Unknown

6) SPECIMEN COLLECTION DATE

_____/_____/ 200____
month day

7) AGE:_____
years

8) IF < 1 YEAR, AGE: _____
months

9) SUBMITTING LAB:

_____

_____
Laboratory

9a) SUBMITTING PHYSICIAN:

_____

Phone: ( ) _____ -_____

Informant _____ **Date Report Received in Lab** _____/_____/ 200____
month day

10) SOURCE OF SPECIMEN: ☐ Stool ☐ GI Aspirate ☐ Small Bowel Biopsy ☐ Unknown ☐ Other site (specify):_____

_____

11) ISOLATED PARASITIC ORGANISM:

☐ ***Cryptosporidium***

How identified? (Please check all that apply):

☐ Wet mount, not stained
☐ Wet mount, temporary stain, type: _____
☐ Acid fast, type: _____
☐ FA (Direct immunofluorescence)
☐ ELISA, specify immunoassay method:_____
☐ PCR
☐ Rapid Cartridge Assay
☐ Other, please specify:_____

☐ ***Cyclospora***

How identified? (Please check all that apply):

☐ Wet mount, not stained
☐ Wet mount, temporary stain, type: _____
☐ Wet mount, autofluorescence
☐ Acid fast, type: _____
☐ Safranin, type: _____
☐ PCR
☐ Other, please specify:_____

Foodborne Diseases Active Surveillance Network (FoodNet) Case Report Parasitic Form

Data Entry: ☐ NEDSS ☐ PHLIS ☐ STATE SYSTEM ☐ CASE-CONTROL STUDY ☐ EPI INFO

A. Hospital Follow-up:

12) PATIENT STATUS AT THE TIME OF SPECIMEN COLLECTION:

☐ Hospitalized (*go to 14*) ☐ Unknown (*go to 14c*)

☐ Outpatient (*go to 13*)

12a) OISD (Other immunosuppressive diseases):

☐ Yes ☐ No ☐ Not available

---

13) IF OUTPATIENT, WAS THE PATIENT SUBSEQUENTLY HOSPITALIZED?

☐ Yes (*go to14*) ☐ No (*go to 14c*) ☐ Unknown (*go to 14c*)

---

14) IF PATIENT WAS HOSPITALIZED
(that is, if answered "Hospitalized" to #12 or "Yes" to #13):

Hospital name:_____

Date of first admission: _____ /_____ / 200___
month day

Date of last discharge: _____ /_____ / 200___
month day

14a) TRANSFERRED TO ANOTHER HOSPITAL?

☐ Yes ☐ No ☐ Unknown

14b) If Yes, TRANSFER HOSPITAL NAME:

_____

14c) HOW WAS THE INFORMATION (from #12,13, or 14) DETERMINED?

☐ Patient / relative contacted

☐ Physician contacted or chart review / medical records review

☐ Did not follow up

☐ County provided information

---

15) OUTCOME: ☐ Alive ☐ Dead ☐ Unknown

15a) HOW WAS THIS INFORMATION (from #15) DETERMINED?

☐ Patient / relative contacted

☐ Physician contacted or chart review/medical records review

☐ Did not follow up

☐ County provided information

B. Health Department Follow-up:

If the isolate was further characterized by the State Lab, please update #11.

16) DID THE STATE LAB RECEIVE THE ISOLATE?

☐ Yes ☐ No ☐ Unknown

16a) If Yes, STATE LAB ISOLATE ID NUMBER:

_____

17) DID THE PATIENT TRAVEL OUTSIDE THE U.S. WITHIN THE LAST 15 DAYS?

☐ Yes (*go to 17a)* ☐ No (*go to 18)* ☐ Unknown (*go to 18)*

17a)

Date of departure from the U.S. : _____ /_____ / 200___
month day

Date of return to the U.S. : _____ /_____ / 200___
month day

---

18) WAS CASE FOUND DURING AN AUDIT?

☐ Yes ☐ No ☐ Unknown

---

19) WAS THE CASE PART OF AN OUTBREAK?

☐ Yes (*go to 19a)* ☐ No (*go to 20)* ☐ Unknown (*go to 20)*

19a) IF OUTBREAK RELATED, WAS IT A FOODBORNE OUTBREAK?

☐ Yes (*go to 19b)* ☐ No (*go to 20)* ☐ Unknown (*go to 20)*

19b) CDC EFORS NUMBER: _____

---

20) IF AVAILABLE, PLEASE INDICATE:

Date of illness onset: ____ /_____ / 200___ ☐ Not Available
month day

Date of diarrhea onset: ____ /_____ / 200__ ☐ Not Available
month day

---

21) WAS CASE ENROLLED IN A CASE-CONTROL STUDY?

☐ Yes ☐ No ☐ Unknown

If No, Reason: _____

Reason Code: _____

---

22) IS CASE REPORT COMPLETE? ☐ Yes ☐ No

22a) If Yes, DATE CASE REPORT COMPLETED:

_____ /_____ / 200____
month day

22b) INITIALS OF PERSON COMPLETING CASE REPORT:

_____

Comments_____

Revised 5/17/05