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OMB No. 0920-0009

CYCLOSPORIASIS SURVEILLANCE CASE REPORT FORM

Demographic data:

Patient's name (first 4 letters of last name): _____ **Sex:** ☐ Male ☐ Female

State of residence: _____ **County:** _____ **Age:** ____ **Date of birth** (mm/yyyy): _____

Ethnic origin:
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown

Race *(check all that apply):*
☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander
☐ Unknown

Physician's name: _____

Phone: _____ **FAX:** _____ **Email:** _____

Clinical data: *(For dates, be as specific as possible. However, approximations [e.g., mm/yyyy] are okay.)*

Date of onset of illness / symptoms: _____ (☐ Unknown date; unable to approximate)

Signs and symptoms:

Diarrhea: ☐ Yes ☐ No ☐ Unknown
If yes, maximum number stools per day: _____ *(unknown = 999)*

Weight loss: ☐ Yes ☐ No ☐ Unknown
If yes, baseline weight: _____ lbs. *(unknown = 999)*
Number of pounds lost: _____

Fever (or felt feverish): ☐ Yes ☐ No ☐ Unknown
If yes, temperature: _____degrees F *(unknown or not measured = 999)*

Fatigue:	☐ Yes	☐ No	☐ Unknown
Anorexia:	☐ Yes	☐ No	☐ Unknown
Nausea:	☐ Yes	☐ No	☐ Unknown
Vomiting:	☐ Yes	☐ No	☐ Unknown
Abdominal cramps:	☐ Yes	☐ No	☐ Unknown

Other symptoms *(specify):* _____

Hospitalized *(at least overnight)*: ☐ Yes ☐ No ☐ Unknown
If yes, name of hospital: _____ Date of admission: _____

Date stool collected for *Cyclospora* testing: _____ *(If multiple stools, specify below or on p. 2.)*

Test results: ☐ Positive ☐ Negative ☐ Unknown (or pending)

If known, specify testing methods and laboratories, including, if applicable, testing done by state or CDC labs:
_____

Results from **state lab** (not applicable: ☐):	☐ Positive	☐ Negative	☐ Unknown (or pending)
Results from **CDC lab** (not applicable: ☐):	☐ Positive	☐ Negative	☐ Unknown (or pending)

Has the case-patient been treated (or is he/she being treated) for cyclosporiasis? ☐ Yes ☐ No ☐ Unknown
If yes, what medication(s)? ☐ Trimethoprim/sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)
☐ Other *(specify):* _____
☐ Unknown

Is case-patient allergic to (or intolerant of) sulfa drugs? ☐ Yes ☐ No ☐ Unknown

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, GA 30333; ATTN: PRA (0920-0009).

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Exposures during 2 weeks before onset of illness:

(For dates, be as specific as possible. However, approximations [e.g., mm/yyyy] are okay.)

History of travel *(during **2 weeks** before onset of illness)*: ☐ Yes ☐ No ☐ Unknown

International travel **(country):** (☐ **Unknown dates of travel and unable to approximate)**

(1) _____ Departure date: _____ Return date: _____
(2) _____ Departure date: _____ Return date: _____
(3) _____ Departure date: _____ Return date: _____

U.S. travel **(state):** (☐ **Unknown dates of travel and unable to approximate)**

(1) _____ Departure date: _____ Return date: _____
(2) _____ Departure date: _____ Return date: _____
(3) _____ Departure date: _____ Return date: _____

Fresh produce exposures *(produce **eaten or tasted** during **2 weeks** before onset of illness)*:

Fresh berries: ☐ Yes *(If yes, specify types; check all that apply)* ☐ No ☐ Unknown
☐ Strawberries ☐ Blackberries ☐ Blueberries
☐ Raspberries ☐ Black raspberries ☐ Golden raspberries ☐ Unknown type of berry
☐ Other types of berries *(specify)*: _____

Fresh herbs: ☐ Yes *(If yes, specify types; check all that apply)* ☐ No ☐ Unknown
☐ Cilantro ☐ Oregano ☐ Thyme ☐ Mint ☐ Dill ☐ Parsley ☐ Rosemary
☐ Basil *(specify types)*: ☐ Sweet basil ☐ Thai basil *(i.e., green leaves and purple stems)*
☐ Purple basil *(i.e., purple leaves and stems)*
☐ Other types of herbs *(specify)*: _____
☐ Unknown type of herb

Lettuce: ☐ Yes *(If yes, specify types; check all that apply)* ☐ No ☐ Unknown
☐ Mesclun (a.k.a., spring mix, field greens, baby greens, & gourmet salad mix)
☐ Arugula
☐ Other types of lettuce *(specify)*: _____
☐ Unknown type of lettuce

Other types of fresh produce: ☐ Yes *(If yes, specify types; check all that apply)* ☐ No ☐ Unknown
☐ Fruit, other than berries *(specify types)*: _____
☐ Snow peas *(flat, shiny pea pods containing tiny peas)*
☐ Other types of fresh produce *(specify)*: _____
☐ Unknown type of fresh produce

Did the case-patient attend any events (e.g., wedding reception) *(during **2 weeks** before onset of illness)?*
☐ Yes ☐ No ☐ Unknown
If yes, specify type of social or other event: _____ Event date: _____

Does the case-patient know of other ill persons? ☐ Yes ☐ No ☐ Unknown
If yes, did health department obtain contact information and investigate further *(provide comments below)*?
☐ Yes ☐ No ☐ Under consideration (or pending) ☐ Unknown

Comments and additional data: Change Text Size

Name *(person filling out form)*: _____ **Title:** _____
Phone: _____ **FAX:** _____ **Email:** _____
Name of investigating health department: _____ **Date form submitted:** 06/26/2012

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