

**Cryptosporidiosis Case Surveillance Form**  
**Ohio Department of Health**

In April 1995 cryptosporidiosis was established as a Class A notifiable disease in Ohio. The Institute of Medicine has categorized the disease as an emerging infection but there is a general lack of knowledge regarding the magnitude of the problem and the risk of infection. In order to help us learn more about cryptosporidiosis, please complete this form for each reported case and mail it to: Bureau of Infectious Disease Control, Ohio Department of Health, PO Box 118, Columbus, OH 43266-0118. PLEASE DO NOT FAX THIS FORM TO ODH.

Local Health Department \_\_\_\_\_ Date \_\_\_\_\_  
Name of person completing this form \_\_\_\_\_  
Information obtained from \_\_\_\_\_ by telephone/home visit  
(name) (circle one)

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**Case Information**

Case name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Sex: (circle one) M F Unk Age: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation: \_\_\_\_\_

**Race:**

\_\_\_\_\_ White \_\_\_\_\_ Native American  
\_\_\_\_\_ Black \_\_\_\_\_ Other: \_\_\_\_\_  
\_\_\_\_\_ Asian \_\_\_\_\_ Unknown

**Ethnicity:**

\_\_\_\_\_ Hispanic  
\_\_\_\_\_ Non-Hispanic  
\_\_\_\_\_ Unknown

Parent/Guardian: Last name \_\_\_\_\_ First name \_\_\_\_\_

Illness onset date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Duration of illness: \_\_\_\_\_ (days)

Symptoms: \_\_\_\_\_

Was patient hospitalized: Y N Unk (circle one)

If yes, name of hospital: \_\_\_\_\_

Date admitted: \_\_\_\_\_ Date discharged: \_\_\_\_\_

### HOUSEHOLD CONTACTS

<u>Name</u>	<u>Relation to Index Case</u>	<u>Age</u>	<u>Ill (Y/N)</u>	<u>Onset Date</u>	<u>Symptoms</u>	<u>Duration (days)</u>	<u>Occupation</u>
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(Please indicate with an asterisk (\*) those cases that are lab confirmed.)

**The remainder of the questionnaire applies to all household members, including the case. It will assist in determining possible exposures and risk factors.**

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|---|-------------------------|
| 1. Does anyone in the household attend or work at a home day care, child care center, or preschool? | (Circle one)<br>Y N Unk |
|---|-------------------------|

If yes, name of person(s), and name, address of facility:

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|---|---------|
| 2. Is anyone in the household employed as a food handler (directly prepares or touches food) or as a caregiver in a hospital, nursing home, or other institution? | Y N Unk |
|---|---------|

If yes, name of person(s) and name, address of facility:

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3. What is the usual source of water for the household? (Check all that apply.)

municipal \_\_\_ well \_\_\_ spring \_\_\_ bottled \_\_\_ other \_\_\_\_\_

- |                                     |         |
|-------------------------------------|---------|
| 4. Are there pets in the household? | Y N Unk |
|-------------------------------------|---------|

If yes, list: \_\_\_\_\_

5. Does any symptomatic member of the household have impaired immune function or an underlying medical condition (history of organ transplant, chemotherapy, HIV, diabetes, kidney dialysis, etc.)? Y N Unk

If yes, name of person: \_\_\_\_\_

The following questions refer to the month prior to the onset of illness of the first sick person in the household:

6. Have any household members traveled outside of the USA? Y N Unk

If yes, name of person(s), country and travel dates: \_\_\_\_\_

7. Did any household members go camping, hiking, swimming or fishing? Y N Unk

If yes, name of person(s), location and dates: \_\_\_\_\_

8. Have any household members consumed raw milk? Y N Unk

If yes, name of person(s): \_\_\_\_\_

9. Have any household members had contact with farm animals (calves, cattle, sheep, etc.)? Y N Unk

If yes, name of person(s), type of animal, date of contact: \_\_\_\_\_

10. Has any household member had contact with other persons with diarrheal disease outside the household (i.e., in child care center, friends, etc.)? Y N Unk

If yes, name of person(s) and place of contact: \_\_\_\_\_

Please mail this form (do not fax) to: Bureau of Infectious Disease Control, Ohio Department of Health, PO Box 118, Columbus, OH 43266-0118.

Thank you for your assistance. If testing is needed for contact follow-up, please call Infectious Disease Control to make arrangements: (614) 995-5599.