

FOR HEALTH DEPARTMENT USE ONLY:

Medical care facility _____ Visit date(s) _____
Treating Physician _____ Outbreak # _____

ODH USE ONLY

Date of this report _____
Interviewer initials _____
Report number _____

HARMFUL ALGAL BLOOM-RELATED HUMAN ILLNESS REPORT— DRINKING WATER

Identifying information for ill individuals:

Name _____
Phone _____
Address _____
County _____
ZIP code _____
Name of interviewee _____ Relationship _____

Source(s) of report:

Resident Address _____
 Healthcare Provider _____
 State Agency Phone number _____
 County Agency _____
 Poison Control Center _____
 Medical record _____
 Other _____

Demographics

Date of birth _____ or Age _____ Sex Male Female Height _____ inches Weight _____ lbs
Race American Indian Asian/Pacific Islander Black White Unknown Other _____ Hispanic Yes No

Exposure Information

Between _____ (dates), what was your primary source of drinking water?
 Well water Municipal water from tap (specify Water Utility if known) _____ Commercially bottled water Other (specify) _____
If you drank **municipal water from tap**, where did you drink it? (Check all that apply)
 Home Work School Daycare Other (specify) _____ Address _____

Between _____, did you drink any tap water (even if it was only a mouthful)?
 Yes No

If yes, how much did you drink?
 A mouthful A cup (8 ounces) More than a cup _____ (# cups)
Between _____, did you use tap water to make coffee or tea?
 Yes No
If yes, how much did you drink?
 A mouthful A cup (8 ounces) More than a cup _____ (# cups)
Between _____, did you use tap water to make other beverages (e.g. fruit juice, powdered drink mix)?
 Yes No

If yes, how much did you drink?
 A mouthful A cup (8 ounces) More than a cup _____ (# cups)
Between _____, did you use ice made from tap water in any additional beverages?
 Yes No

Between _____, did you use tap water to make baby formula?
 Yes No

If yes, how many ounces did the child drink? _____ ounces
Between _____, did you use tap water in cooking or preparing food? ((e.g. soup, pasta, rice, cereal, potatoes, vegetables)
 Yes No

Between _____, did you use tap water to brush your teeth or clean dentures?
 Yes No

If yes, did you swallow any tap water?
 Yes No

Between _____, did you use tap water in a nasal/sinus irrigator or Neti pot?
 Yes No

Between _____, did you use tap water to shower?
 Yes No

If yes, did you swallow any water?
 Yes No

How long was your shower? _____ minutes

Between _____, did you use tap water to take a bath?
 Yes No

If yes, did you swallow any water?
 Yes No
How long was your bath? _____ minutes

Between _____, did you use tap water to wash your hands/face?
 Yes No
If yes, how many times did you wash your hands/face? _____

Between _____, did you use tap water to wash fruits or vegetables?
 Yes No
If yes, did you wear gloves?
 Yes No

Between _____, did you use tap water to hand wash dishes?
 Yes No
If yes, did you wear gloves?
 Yes No

Between _____, did you use tap water to water a garden, lawn, or other plants?
 Yes No

Between _____, did you use tap water with a cool mist vaporizer/humidifier, nebulizer or CPAP?
 Yes No

Between _____, did you use tap water for any outdoor recreational activities (e.g. kiddie pool, slip-n-slide, sprinkler)?
 Yes No

If yes, did you swallow any water?
 Yes No

Between _____, did you have any other exposure to tap water?
 Yes No

If yes, please explain: _____

Signs and Symptoms (onset is from time of first exposure, duration is from time of onset)

Symptomatic? Yes No Unknown Date of Onset _____

What symptom(s) did you first experience? _____

Chief symptoms

General

<input type="checkbox"/> Fatigue	Onset _____	Duration _____	<input type="checkbox"/> Loss of appetite	Onset _____	Duration _____
<input type="checkbox"/> Fever	Onset _____	Duration _____	<input type="checkbox"/> Malaise	Onset _____	Duration _____

HEENT

<input type="checkbox"/> Earache	Onset _____	Duration _____	<input type="checkbox"/> Nasal congestion	Onset _____	Duration _____
<input type="checkbox"/> Headache	Onset _____	Duration _____	<input type="checkbox"/> Sore throat	Onset _____	Duration _____
<input type="checkbox"/> Conjunctivitis	Onset _____	Duration _____	<input type="checkbox"/> Other _____	Onset _____	Duration _____

Respiratory

<input type="checkbox"/> Cough	Onset _____	Duration _____	<input type="checkbox"/> Chest tightness	Onset _____	Duration _____
<input type="checkbox"/> Short of breath	Onset _____	Duration _____	<input type="checkbox"/> Other _____	Onset _____	Duration _____
<input type="checkbox"/> Wheezing	Onset _____	Duration _____			

Cardiovascular

<input type="checkbox"/> Chest pain	Onset _____	Duration _____	<input type="checkbox"/> Cyanosis	Onset _____	Duration _____
<input type="checkbox"/> Irregular beat	Onset _____	Duration _____	(check all that apply: _____ arms _____ legs _____ mouth)		
<input type="checkbox"/> Other _____	Onset _____	Duration _____	<input type="checkbox"/> Pale (arms, legs)	Onset _____	Duration _____

Gastrointestinal

<input type="checkbox"/> Nausea	Onset _____	Duration _____	<input type="checkbox"/> Vomiting	Onset _____	Duration _____
<input type="checkbox"/> Diarrhea	Onset _____	Duration _____	<input type="checkbox"/> Pain (up R quadrant)	Onset _____	Duration _____
<input type="checkbox"/> Other _____	Onset _____	Duration _____	<input type="checkbox"/> Bad taste in mouth	Onset _____	Duration _____

Genitourinary

<input type="checkbox"/> Dark urine	Onset _____	Duration _____	<input type="checkbox"/> Other _____	Onset _____	Duration _____
<input type="checkbox"/> Blood in urine	Onset _____	Duration _____			

Musculoskeletal

<input type="checkbox"/> Muscle pain	Onset _____	Duration _____	<input type="checkbox"/> Difficulty walking	Onset _____	Duration _____
<input type="checkbox"/> Joint pain	Onset _____	Duration _____	<input type="checkbox"/> Other _____	Onset _____	Duration _____

Neurologic

<input type="checkbox"/> Confusion	Onset _____	Duration _____	<input type="checkbox"/> Numbness	Onset _____	Duration _____
<input type="checkbox"/> Memory loss	Onset _____	Duration _____	<input type="checkbox"/> Weakness	Onset _____	Duration _____
<input type="checkbox"/> Seizure	Onset _____	Duration _____	<input type="checkbox"/> Paralysis	Onset _____	Duration _____
<input type="checkbox"/> Coma	Onset _____	Duration _____	<input type="checkbox"/> Vertigo	Onset _____	Duration _____
<input type="checkbox"/> Other _____	Onset _____	Duration _____	<input type="checkbox"/> Tingling/burning	Onset _____	Duration _____
			<input type="checkbox"/> Vision disturbance	Onset _____	Duration _____

Mental health

<input type="checkbox"/> Anxiety/nervousness	Onset _____	Duration _____	<input type="checkbox"/> Other _____	Onset _____	Duration _____
<input type="checkbox"/> Depression	Onset _____	Duration _____			

Dermatologic

<input type="checkbox"/> Itching	Onset _____	Duration _____	<input type="checkbox"/> Rash	Onset _____	Duration _____
<input type="checkbox"/> Blisters	Onset _____	Duration _____	<input type="checkbox"/> Jaundice	Onset _____	Duration _____
<input type="checkbox"/> Other _____	Onset _____	Duration _____			

If rash reported, identify the location of the rash (check all that apply):

Left hand/arm | Right hand/arm Left foot/leg Right foot/leg Face Neck Chest Back
 Under Swimsuit/diaper Other _____

Describe the appearance of the rash

Medical Information

Do you have any pre-existing medical condition(s)?

Yes No Unknown

If yes, check all that apply.

- Asthma
 - Chronic respiratory disease
 - Chronic skin disease
 - Diabetes mellitus
 - Heart disease
 - Immunodeficiency disorder
 - Intestinal disorder (Crohn's disease, Celiac disease)
 - Liver disease (hepatitis, cirrhosis, fatty liver, jaundice)
 - Malignancy
 - Neurologic disorders
 - Psychological disorder
 - Renal disease
- If yes, do you receive dialysis? Yes No
- Transplant recipient
- Other _____

(If female is of reproductive age) Are you currently pregnant or breastfeeding?

Yes No Unknown

Did you use a dietary supplement made from blue-green algae or Super Blue-Green? Yes No Unknown

Do you take herbal supplements or drink herbal teas routinely?

Yes No Unknown

If yes, describe

Did you use any prescribed medication, OTC, or supplements in the month before onset of symptoms?

Yes No Don't know

If yes, list ALL _____

Have you had a cold or flu in the past 2 weeks?

Yes No Don't know

How often do you drink alcohol containing beverage(s)?

Never < 1/wk >1/wk Daily

How many drinks containing alcohol do you drink in a typical day?

1-2 3-4 >5

Did you drink alcohol within 24 hours prior to symptom onset?

Yes No Don't Know

Do you smoke? Yes No Don't Know

If yes, how many packs a day? _____

Is there anything else you would like to add?

FOR HEALTH DEPARTMENT USE ONLY:

Assessment

Medical Care sought Yes No Unknown
If yes, type Clinic ER Urgent care

Visit date(s) _____

Provider _____

Location _____

Phone number _____

Were lab tests conducted Yes No Unknown

If yes, type and results

Blood tests _____

Cultures _____

Fecal smears _____

Histopathology _____

Skin biopsies _____

Toxins _____

Urinalysis _____

X-ray _____

Current disposition?

Released Still hospitalized Unknown Deceased

Notes: _____

If deceased, was an autopsy performed?

Yes No Pending Unknown

[If yes, attach copy]

Illness report status Complete

Follow-up required (describe in follow-up section)

Case classification

- Not a HAB-related case
- Suspect HAB-related case*
- Probable HAB-related case*
- Confirmed HAB-related case*

Disease(s) associated with this report

- Anatoxin-a poisoning
- Anatoxin-a(s) poisoning
- Cylindrospermopsin poisoning
- Lyngbyatoxin poisoning
- Microcystin poisoning
- Saxitoxin poisoning (Paralytic shellfish poisoning – PSP)
- Other _____

If not HAB-related, what diagnosis _____

Notes _____

Source of final diagnosis _____

Follow-up needed Yes No

Photos Yes No (If yes, attach a signed release)

Report by (name) _____

*based on CDC case definitions on page 4

Other exposed people _____

Description _____

CDC case definition summary for selected toxins:

NOTE: We do not have definite case definitions for these poisonings. We cannot rule out that a person may present with symptoms immediately after exposure or days after exposure.

Suspect Case

Exposure to water or to seafood with a confirmed algal bloom AND onset of associated signs and symptoms within a reasonable time after exposure AND without identification of another cause of illness

Probable Case

Meets criteria for *Suspect Case* AND there is laboratory documentation of a HAB toxin(s) in the water

Confirmed Case

Meets criteria for a *Probable Case* combined with professional judgment based on medical review

Freshwater Cyanotoxins	Type of Toxin	Causative organism	Vector
Anatoxin-a	Neurotoxin	Anabaena spp. Aphanizomenon spp. Planktothrix spp.	Contaminated fresh water
Anatoxin-a(s)	Neurotoxin	Anabaena flos-aquae	Contaminated fresh water
Cylindrospermopsin	Hepatotoxin	Cylindrospermopsis raciborskii, Aphanizomenon ovalisporum	Contaminated fresh water and possibly fish
Lyngbyatoxin	Dermal toxin	Lyngbya spp.	Contaminated fresh or marine water
Microcystin	Hepatotoxin	M. aeruginosa Anabaena spp. Planktothrix spp.	Contaminated fresh water
Saxitoxin	Neurotoxin	Anabaena circinalis Lyngbya wolle	Contaminated fresh water

Numeric Thresholds for Ohio Public Water

The recommended thresholds would be protective of human exposures. The thresholds given here may or may not be protective of animals such as dogs or livestock.

Threshold (µg/L)	Microcystin***	Anatoxin-a	Cylindrospermopsin	Saxitoxin***
Drinking Water-Do Not Drink	0.3*	20	0.7*	0.2
Drinking Water-Do Not Use**	20	300	20	3

* Numeric thresholds are referenced from the U.S. EPA Health Advisories (<http://yosemite.epa.gov/opa/admpress.nsf/0/547dc50c15c82aaf85257e3d004d7f67?OpenDocument>)

** The Drinking Water 'Do Not Use' thresholds are based on the Recreational No Contact Advisory thresholds from the Ohio EPA Public Water System Harmful Algal Bloom Response Strategy (<http://epa.ohio.gov/ddagw/HAB.aspx>)

***Microcystin and Saxitoxin thresholds are intended to be applied to total concentrations of all reported congeners of those toxins.

Healthcare Providers: Please fax form to the local health department of the residence of the ill individual. A list may be found at: <http://www.odh.ohio.gov/~media/ODH/ASSETS/Files/lhd/OHIO-LHDcontact.ashx>

If you are unable to identify the residence, please send to your local health department.

Local health departments please fax forms to:
(614) 466-4556
 Harmful Algal Blooms (HAB)
 Bureau of Environmental Health (BEH)
 Ohio Department of Health (ODH)



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