State of California—Health and Human Services Agency

Local ID Number: _____

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

# CYCLOSPORIASIS CASE REPORT

*Please complete this form for confirmed and probable cases of cyclosporiasis. For case definition, see page 6.* ***Completion of this form is not required.*** *This form was developed as a tool for local health departments to interview patients in a standardized manner and may help with cluster investigations. Jurisdictions participating in CalREDIE should create a CalREDIE incident and enter the information directly into the CalREDIE system. Jurisdictions not participating in CalREDIE should maintain the form at the local jurisdiction.* ***Please do not fax or send hard copy of the forms to CDPH unless requested****.*

## PATIENT INFORMATION

| *Last Name* | *First Name* | *Middle Name* | *Suffix* |
|---|---|---|---|
| | | | |

| *Social Security Number (9 digits)* | *DOB (mm/dd/yyyy)* | *Age* | ☐ Years ☐ Months ☐ Days |
|---|---|---|---|
| | | | |

| *Address Number & Street – Residence* | *Apartment / Unit Number* |
|---|---|
| | |

| *City / Town* | *State* | *Zip Code* |
|---|---|---|
| | | |

| *Census Tract* | *County of Residence* | *Country of Residence* |
|---|---|---|
| | | |

| *Country of Birth* | *If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)* |
|---|---|
| | |

| *Home Telephone* | *Cellular Phone / Pager* | *Work / School Telephone* |
|---|---|---|
| | | |

| *E-mail Address* | *Other Electronic Contact Information* |
|---|---|
| | |

| *Work / School Location* | *Work / School Contact* |
|---|---|
| | |

*Gender*
☐ Female ☐ Trans female / transwoman ☐ Genderqueer or non-binary ☐ Unknown
☐ Male ☐ Trans male/ transman ☐ Identity not listed ☐ Declined to answer

| *Pregnant?* ☐ Yes ☐ No ☐ Unknown | *If Yes, Est. Delivery Date (mm/dd/yyyy)* |
|---|---|
| | |

| *Medical Record Number* | *Patient's Parent/Guardian Name* |
|---|---|
| | |

| *Occupation Setting (see list on page 8)* | *Other Describe/Specify* |
|---|---|
| | |

| *Occupation (see list on page 8)* | *Other Describe/Specify* |
|---|---|
| | |

*Primary Language*
☐ English
☐ Spanish
☐ Other: _____

*Ethnicity (check one)*
☐ Hispanic/Latino
☐ Non-Hispanic/Non-Latino
☐ Unknown

*Race(s)*
*(check all that apply, race descriptions on page 7)*

*The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.*

☐ American Indian or Alaska Native

☐ Asian *(check all that apply, see list on page 7)*
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African-American

☐ Native Hawaiian or Other Pacific Islander *(check all that apply, see list on page 7)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Fijian
- ☐ Tongan
- ☐ Guamanian
- ☐ Other: _____

☐ White

☐ Other: _____

☐ Unknown

## ADDITIONAL PATIENT DEMOGRAPHICS

*Sex Assigned at Birth*
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

*Sexual Orientation*
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

First three letters of patient's last name: | | | |

## CLINICAL INFORMATION

| *Physician Name - Last Name* | *First Name* | *Telephone Number* |
|---|---|---|
| | | |

## *SIGNS AND SYMPTOMS*

| *Symptomatic?* ☐ Yes ☐ No ☐ Unknown | *If Yes, Onset Date of Symptoms (mm/dd/yyyy)* | *Onset Time (hh:mm)* | *Specify AM/PM* ☐ AM ☐ PM |
|---|---|---|---|
| | *Duration of Symptoms (days)* ☐ Still symptomatic as of _____ (mm/dd/yyyy) | | |

| **Signs and Symptoms** | **Yes** | **No** | **Unk** | **If Yes, Specify as Noted** | |
|---|---|---|---|---|---|
| Diarrhea (3 or more loose stools in a 24-hour period) | | | | *Max. Number of Stools in 24-hr Period* | *Onset Date of Diarrhea (mm/dd/yyyy)* |
| | | | | *Diarrhea end date (mm/dd/yyyy)* ☐ Diarrhea ongoing as of _____ (mm/dd/yyyy) | |
| Weight loss | | | | | |
| Fever (>100.4 °F or 38 °C) | | | | *Subjective or Measured Temperature* ☐ Subjective ("felt hot") ☐ Unknown ☐ Measured | *If Measured, Highest Temperature (°F or °C)* |
| Fatigue | | | | | |
| Anorexia | | | | | |
| Nausea | | | | | |
| Vomiting | | | | | |
| Abdominal cramps | | | | | |

*Other Signs / Symptoms*

## *PAST MEDICAL HISTORY*

| *Does the patient have underlying conditions relevant to present illness? (e.g., renal disease, diabetes, immunocompromising conditions)* ☐ Yes ☐ No ☐ Unknown | *If Yes, specify type of condition. Please do NOT disclose or specify HIV/AIDS information on this form.* |
|---|---|

## *HOSPITALIZATION*

*Did patient visit the emergency room for illness?* ☐ Yes ☐ No ☐ Unknown

| *Was patient hospitalized?* ☐ Yes ☐ No ☐ Unknown | *If Yes, how many total hospital nights?* ☐ *Still hospitalized as of* _____ *(mm/dd/yyyy)* |
|---|---|

*During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)?* ☐ Yes ☐ No ☐ Unknown

*If there were any ER or hospital stays related to this illness, specify details in the Hospitalization – Details section below.*

## *HOSPITALIZATION – DETAILS*

| | | | | | |
|---|---|---|---|---|---|
| *Hospital Name 1* | *Street Address* | | | *Admit Date (mm/dd/yyyy)* | |
| | *City* | | | *Discharge / Transfer Date (mm/dd/yyyy)* | |
| | *State* | *Zip Code* | *Telephone Number* | *Medical Record Number* | *Discharge Diagnosis* |
| *Hospital Name 2* | *Street Address* | | | *Admit Date (mm/dd/yyyy)* | |
| | *City* | | | *Discharge / Transfer Date (mm/dd/yyyy)* | |
| | *State* | *Zip Code* | *Telephone Number* | *Medical Record Number* | *Discharge Diagnosis* |

First three letters of patient's last name: | | | |

## TREATMENT / MANAGEMENT

| *Is the patient allergic to (or intolerant of) sulfa drugs (e.g., Bactrim [trimethoprim-sulfamethoxazole])?* ☐ Yes ☐ No ☐ Unknown | *If Yes, specify the extent of the allergic reaction/intolerance.* |
|---|---|
| *Received medical treatment (e.g., antibiotics)?* ☐ Yes ☐ No ☐ Unknown | *If Yes, specify the treatments below.* |

## TREATMENT / MANAGEMENT – DETAILS

| | | |
|---|---|---|
| *Treatment Type 1*<br>☐ Antibiotic<br>☐ Other: _____ | *Name*<br>☐ Trimethoprim-sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)<br>☐ Other (specify): _____<br>☐ Unknown | *Date Started (mm/dd/yyyy)*<br>*Date Ended (mm/dd/yyyy)* |
| *Treatment Type 2*<br>☐ Antibiotic<br>☐ Other: _____ | *Name*<br>☐ Trimethoprim-sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)<br>☐ Other (specify): _____<br>☐ Unknown | *Date Started (mm/dd/yyyy)*<br>*Date Ended (mm/dd/yyyy)* |
| *Treatment Type 3*<br>☐ Antibiotic<br>☐ Other: _____ | *Name*<br>☐ Trimethoprim-sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)<br>☐ Other (specify): _____<br>☐ Unknown | *Date Started (mm/dd/yyyy)*<br>*Date Ended (mm/dd/yyyy)* |

## OUTCOME

| *Outcome?* ☐ Survived ☐ Died ☐ Unknown | *If Survived,*<br>*Survived as of _____ (mm/dd/yyyy)* | *Date of Death (mm/dd/yyyy)* |
|---|---|---|

## LABORATORY INFORMATION

## LABORATORY TESTING RESULTS

| *Specimen Type* ☐ Stool ☐ Blood ☐ Urine ☐ Other (specify): _____ | | *Collection Date (mm/dd/yyyy)* |
|---|---|---|
| *Cyclospora Test Result*<br>☐ Positive<br>☐ Negative<br>☐ Unknown<br>☐ Not done | *Testing Methods:*<br>☐ O&P (e.g., microscopy, stained smears)<br>☐ GI PCR Panel (e.g., BioFire FilmArray®)<br>☐ PCR (i.e., standalone PCR test, not part of a panel)<br>☐ Other (specify): _____ | |
| | *Laboratory Name* | *Specimen ID* |

## PUBLIC HEALTH LABORATORY TESTING

| | | | |
|---|---|---|---|
| *Was specimen tested at a local public health lab?* ☐ Yes ☐ No ☐ Unknown | *Local Public Health Laboratory Name* | | *Local Laboratory Specimen ID Number* |
| *Was specimen tested at a state public health lab?* ☐ Yes ☐ No ☐ Unknown | *State Public Health Laboratory Name* ☐ MDL ☐ Other: _____ | | *State Laboratory Specimen ID Number* |
| *Was genetic sequencing completed (e.g., amplicon or targeted regions sequencing, WGS)?* ☐ Yes ☐ No ☐ Unknown | *Laboratory Name* ☐ MDL ☐ Other: _____ | *Sequence ID Number* | *Specify Results (e.g., haplotypes) or Attach* |
| *Was specimen forwarded to CDC?* ☐ Yes ☐ No ☐ Unknown | *Date Sent to CDC (mm/dd/yyyy)* | *CDC Laboratory Results / Comments / Notes* | |

First three letters of patient's last name: | | | |

## EPIDEMIOLOGIC INFORMATION

**INCUBATION PERIOD: 14 DAYS PRIOR TO ILLNESS ONSET**

_____ to _____
*(onset date minus 14 days)* *(onset date)*

### *TRAVEL HISTORY - INTERNATIONAL*

*Did patient travel **internationally*** during the **incubation period**?*
☐ Yes ☐ No ☐ Unknown

*If Yes, specify all locations and dates below.*

** Please note, for cyclosporiasis surveillance, travel to U.S. territories Puerto Rico and the U.S. Virgin Islands is considered domestic travel. Travel to other U.S. territories and countries is considered international travel.*

### *INTERNATIONAL TRAVEL HISTORY – DETAILS*

| Country | Other location details (city, resort, etc.) | Date Travel Started *(mm/dd/yyyy)* | Date Travel Ended *(mm/dd/yyyy)* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

### *TRAVEL HISTORY – DOMESTIC*

*Did patient travel **domestically*** during the **incubation period**?*
☐ Yes ☐ No ☐ Unknown

*If Yes, specify all locations and dates below.*

** Domestic travel includes travel to another county or state, Washington D.C., Puerto Rico, and the U.S. Virgin Islands.*

### *DOMESTIC TRAVEL HISTORY – DETAILS*

| Travel Type | County / State / Other | City / Cities | Other location details (resort, etc.) | Date Travel Started *(mm/dd/yyyy)* | Date Travel Ended *(mm/dd/yyyy)* |
|---|---|---|---|---|---|
| ☐ Another California county<br>☐ Another state or Washington D.C.<br>☐ Other domestic travel (e.g., Puerto Rico or U.S. Virgin Islands) | | | | | |
| ☐ Another California county<br>☐ Another state or Washington D.C.<br>☐ Other domestic travel (e.g., Puerto Rico or U.S. Virgin Islands) | | | | | |
| ☐ Another California county<br>☐ Another state or Washington D.C.<br>☐ Other domestic travel (e.g., Puerto Rico or U.S. Virgin Islands) | | | | | |

### *SURVEILLANCE INSTRUCTIONS*

**For patients who did not report a history of international travel:**

Please consider administering the CDC Cyclosporiasis National Hypothesis Generating Questionnaire by using the REDCap survey at https://redcap.link/CACNHGQ. If the REDCap survey is unavailable, please complete the fillable PDF located in the CalREDIE Document Repository. If you use the fillable PDF, please upload the completed questionnaire into the CalREDIE filing cabinet. If an increase in non-travel associated cyclosporiasis is detected, these questionnaires will facilitate the investigation into a potential domestic outbreak.

Any questions may be directed to the Infectious Diseases Branch (IDB-DIS@cdph.ca.gov, 510-620-3434).

First three letters of patient's last name: | | | |

## EVENTS

| Did patient attend any events (e.g., wedding reception, party) during the 14 days before onset of illness? ☐ Yes ☐ No ☐ Unknown | If Yes, specify event details in section below. |
|---|---|

## EVENTS - DETAILS

| | | | |
|---|---|---|---|
| Event 1 Type (e.g., wedding reception, party) | Location (cross-streets, city) | | Event Date (mm/dd/yyyy) |
| | Foods Eaten | Were there other ill attendees? ☐ Yes ☐ No ☐ Unknown | If Yes, how many? |
| Event 2 Type (e.g., wedding reception, party) | Location (cross-streets, city) | | Event Date (mm/dd/yyyy) |
| | Foods Eaten | Were there other ill attendees? ☐ Yes ☐ No ☐ Unknown | If Yes, how many? |

## ILL CONTACTS

| Any contacts with similar illness (including household contacts)? ☐ Yes ☐ No ☐ Unknown | If Yes, specify details below. |
|---|---|

## ILL CONTACTS – DETAILS

| | | | | | | |
|---|---|---|---|---|---|---|
| Name 1 | Age | Gender | Telephone Number | Email Address | Type of Contact / Relationship | Date of Contact (mm/dd/yyyy) |
| | Street Address | | | | Exposure Event | Illness Onset Date (mm/dd/yyyy) |
| | City | | State | Zip Code | Laboratory confirmed? ☐ Yes ☐ No ☐ Unknown | CalREDIE ID (if applicable) |
| Name 2 | Age | Gender | Telephone Number | Email Address | Type of Contact / Relationship | Date of Contact (mm/dd/yyyy) |
| | Street Address | | | | Exposure Event | Illness Onset Date (mm/dd/yyyy) |
| | City | | State | Zip Code | Laboratory confirmed? ☐ Yes ☐ No ☐ Unknown | CalREDIE ID (if applicable) |
| Name 3 | Age | Gender | Telephone Number | Email Address | Type of Contact / Relationship | Date of Contact (mm/dd/yyyy) |
| | Street Address | | | | Exposure Event | Illness Onset Date (mm/dd/yyyy) |
| | City | | State | Zip Code | Laboratory confirmed? ☐ Yes ☐ No ☐ Unknown | CalREDIE ID (if applicable) |

## NOTES / REMARKS

## REPORTING AGENCY

| Investigator Name | Local Health Jurisdiction | Telephone Number | Date form completed (mm/dd/yyyy) |
|---|---|---|---|
| First Reported By ☐ Clinician ☐ Laboratory ☐ Other (specify): _____ | | Health education provided? ☐ Yes ☐ No ☐ Unknown | |

## EPIDEMIOLOGICAL LINKAGE

| Epi-linked to known case? ☐ Yes ☐ No ☐ Unknown | Contact Name / Case Number |
|---|---|

First three letters of patient's last name: | | | |

## *DISEASE CASE CLASSIFICATION*

*Case Classification (see case definition below)*

☐ Confirmed ☐ Probable

## *OUTBREAK*

*Part of known outbreak?*

☐ Yes ☐ No ☐ Unknown

*If Yes, extent of outbreak:*

☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other: _____

*Mode of Transmission*

☐ Point source ☐ Person-to-person ☐ Unknown ☐ Other: _____

*Vehicle of Outbreak*

*CDC Cluster Code*

*CDC NORS Outbreak ID Number*

## *STATE USE ONLY*

*State Case Classification*

☐ Confirmed ☐ Probable ☐ Not a case ☐ Need additional information

## CASE DEFINITION

### CYCLOSPORIASIS (2010)

### CLINICAL DESCRIPTION

An illness of variable severity caused by the protozoan parasite *Cyclospora cayetanensis*. The most common symptom is watery diarrhea. Other common symptoms include loss of appetite, weight loss, abdominal cramps/bloating, nausea, body aches, and fatigue. Vomiting and low-grade fever also may be noted.

### LABORATORY CRITERIA FOR DIAGNOSIS

Laboratory-confirmed cyclosporiasis shall be defined as the detection of *Cyclospora* organisms or DNA in stool, intestinal fluid/aspirate, or intestinal biopsy specimens.

### CASE CLASSIFICATION

**Probable**

A case that meets the clinical description and that is epidemiologically linked to a confirmed case.

**Confirmed**

A case that meets the clinical description and at least one of the criteria for laboratory confirmation as described above.

First three letters of patient's last name: | | | |

| RACE DESCRIPTIONS | |
|---|---|
| **Race** | **Description** |
| American Indian or Alaska Native | Patient has origins in **any** of the original peoples of North and South America (including Central America). |
| Asian | Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam). |
| Black or African American | Patient has origins in **any** of the black racial groups of Africa. |
| Native Hawaiian or Other Pacific Islander | Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands. |
| White | Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa. |

**ASIAN GROUPS**

- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Iwo Jiman
- Japanese
- Korean
- Laotian
- Madagascar
- Malaysian
- Maldivian
- Nepalese
- Okinawan
- Pakistani
- Singaporean
- Sri Lankan
- Taiwanese
- Thai
- Vietnamese

**NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS**

- Carolinian
- Chamorro
- Chuukese
- Fijian
- Guamanian
- Kiribati
- Kosraean
- Mariana Islander
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- New Hebrides
- Palauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Saipanese
- Samoan
- Solomon Islander
- Tahitian
- Tokelauan
- Tongan
- Yapese

First three letters of patient's last name: | | | |

## OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

## OCCUPATION

- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - waiter or waitress
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - registered nurse
- Medical - other/unknown
- Military - officer
- Military - recruit or trainee
- Protective service - police officer
- Protective service - other
- Professional, technical, or related profession
- Retired
- Sex worker
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high (secondary) school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high (secondary) school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Other
- Refused
- Unknown