

Giardiasis

Alaska

Outbreak **AK STARS** # _____
 Cluster

Date first received by SOE _____ / _____ / _____

OUTREACH/CONTACT LOG (For contact with and/or outreach to the client)

	Method (phone call, letter, homevisit, clinic visit)	Date (mm/dd/yyyy)	Outcome (Left msg., interviewed, refused, unable to locate, etc.)
1st Outreach/Contact		____ / ____ / ____	
2nd Outreach/Contact		____ / ____ / ____	
3rd Outreach/Contact		____ / ____ / ____	

CASE IDENTIFICATION

Name: _____
last first MI Phone(s) _____ Home: _____
 Cell: _____

Address: _____
Street City State Zip

Alternate Contact: Parent/Guardian Spouse/Partner Household Member Other _____

Name: _____
last first MI Phone(s) _____ Home: _____
 Cell: _____

Address: _____
Street City State Zip

DEMOGRAPHICS

Sex: Male Female _____ Hispanic: Yes No Unknown

DOB: ____ / ____ / ____
 mm dd yyyy
 Or, if unknown, Age _____

Race: White
 AI/AN Unknown
 Asian/Pacific Islander Refused to answer
 Black Other _____

CLINICAL DATA

Symptomatic? Yes No Unk ER Visit? Yes No Unk

If yes, onset date ____ / ____ / ____
 mm dd yyyy
 onset time _____ am pm

Duration of Illness _____ hours days
 -OR- Ongoing

Symptoms:

Diarrhea Yes No Unk
 Cramping Yes No Unk
 Nausea Yes No Unk
 Vomiting Yes No Unk
 Loss of Appetite Yes No Unk
 Weight loss Yes No Unk
 Fever Yes No Unk
 Other (specify): _____

Hospitalized? Yes No Unk
 If yes, Hospital name: _____
 Admit date ____ / ____ / ____
 mm dd yyyy
 Discharge date ____ / ____ / ____
 mm dd yyyy
 -OR- Still inpatient Unknown

Outcome: Survived Died (Date: ____ / ____ / ____) Unk

OCCUPATION

Is the case a...	Yes	No	Unk
daycare attendee/worker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
food service/processor worker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
healthcare facility/resident worker?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, specify location/business: _____

Additional clinical information:
 HIV Infection Yes No Unk Receiving chemotherapy/immunosuppressive drugs Yes No Unk

Does the case know others with similar illness? Yes No Unk
 If yes, indicate name of individual, relationship to case, onset of illness, and relevant symptoms: _____

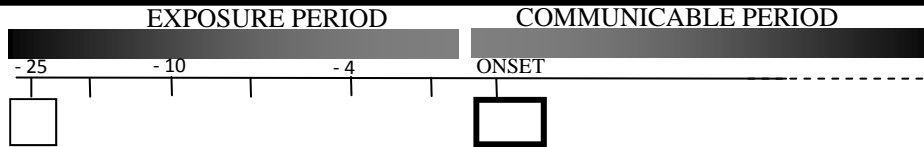
attach a second sheet if needed

CASE NAME: _____

AK STARS # _____

EXPOSURE TIMELINE

Enter symptom onset date into the onset box. Count back to figure the probable exposure period.



The communicable period is variable—weeks to months without treatment. Infected persons without symptoms are more likely to be infectious than those who are sick.

INTERVIEW

Interview questions are asked for the exposure time calculated above.

All yes answers require additional details. If you have a yes answer to any exposure/consumption question, please provide relevant details in the comments section.

Potential Exposures

Yes	No	Unk	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drank untreated water
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attended, visited, or worked at child care center
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contact with diapered or incontinent individuals
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contact with individuals sick with acute gastroenteritis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contact with livestock
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contact with Animal Exhibits (petting zoo, fairs, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contact with Other animals (specify: _____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Contact with sick animal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent arrival from overseas (specify: _____)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational water exposures (e.g. lake, pool, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anal intercourse and/or oral-anal intercourse

Travel Exposure

Yes	No	Unk	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In Alaska
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Outside Alaska
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Outside U.S.
If yes to any travel, specify location(s) and dates of travel.			

If yes to any of the above questions, provide details here:

(e.g. "Drinking untreated water Yes No Unk," relevant details: camping during exposure period, drank water from lake near Haines)

attach a second sheet if needed

Restaurants/takeout during exposure period?

Yes No Unk

Social events (parties, weddings, etc.) during exposure period?

Yes No Unk

If yes to either restaurants or social events, indicate the following: name of restaurant/event, when, where, foods eaten, & if others in attendance became ill.

attach a second sheet if needed

Did case prepare food for public/private gathering during communicability period?

Yes No Unk

If yes, provide details: _____
attach a second sheet if needed

Where were the groceries eaten during the exposure period bought? If unknown, where does client normally buy groceries?

Store name(s) and location(s): _____
attach a second sheet if needed

SUMMARY

Intervention(s): Hygiene education provided Health education provided Child care restriction
 Work or school restriction Other: _____

Completed by _____ Phone _____ Completed Case Report ___ / ___ / ___