

Ciguatera

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, home-visit, 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

Hospitalized? Yes No Unk

If yes, Hospital name: _____
 Admit date _____ / _____ / _____
mm dd yyyy
 Discharge date _____ / _____ / _____
mm dd yyyy
 -OR- Still inpatient Unknown

Duration of Illness _____ hours days
 -OR- Ongoing

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

Symptoms:

Nausea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Reversal of hot/cold sensation <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Metallic taste <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Tingle/numb hands/feet <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Itching <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Tingle/numb mouth/lips/teeth <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Rash <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Abdominal Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Anxiety/irritability/depression <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diff. breathing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Altered heart rate <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Muscle Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Tremors/seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Insomnia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Visual difficulites <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Pain urinating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

CASE NAME: _____

AK STARS # _____

INTERVIEW

Symptoms of Ciguatera typically occur within 24 hrs. If no fish in past 24 hrs, ask about last fish and seafood
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.

Fish Exposure 1

Date fish eaten: ____ / ____ / ____ Time eaten: _____
 mm dd yyyy

Type of Fish: Barracuda Eel Amberjack

Mahi-mahi Grouper Snapper Other: _____

Part of fish consumed : _____

Amount consumed: _____

Any leftovers? Yes No Unk *If yes, acquire the leftovers*

Was fish shared? Yes No Unk *If yes, record names and contact info on next page. Additional restaurant info can also*

Additional info: _____

Fish source: Restaurant Grocery/Market Self Caught

Friend Other : _____

Name of vendor: _____

Vendor location: _____

Location of harvest: _____

Date fish purchased/caught: ____ / ____ / ____
 mm dd yyyy

Fish Exposure 2

Date fish eaten: ____ / ____ / ____ Time eaten: _____
 mm dd yyyy

Type of Fish: Barracuda Eel Amberjack

Mahi-mahi Grouper Snapper Other: _____

Part of fish consumed : _____

Amount consumed: _____

Any leftovers? Yes No Unk *If yes, acquire the leftovers*

Was fish shared? Yes No Unk *If yes, record names and contact info on next page. Additional restaurant info can also*

Additional info: _____

Fish source: Restaurant Grocery/Market Self Caught

Friend Other : _____

Name of vendor: _____

Vendor location: _____

Location of harvest: _____

Date fish purchased/caught: ____ / ____ / ____
 mm dd yyyy

Did the case travel within Alaska or out of state during the exposure period?

Yes No Unk

If yes, complete the following table for ALL ill individuals (*attach a second sheet if needed*):

Type of travel (select all that apply)	Travel destination(s)	Date of Departure	Date of Return
<input type="checkbox"/> Within Alaska <input type="checkbox"/> Outside Alaska <input type="checkbox"/> Outside the U.S.			

CASE NAME: _____

AK STARS # _____

Does the case know others with similar illness, or who ate the same fish meal?

Yes No Unk

If yes, complete the following table for ALL individuals (*attach a second sheet if needed*):

Name	Age (or DOB)	Gender	Relationship to Case	Symptoms	Illness Onset	Illness Duration	Contact Number

Did the case eat fish from restaurants or as takeout during the exposure period?

Yes No Unk

If yes, complete the following for all restaurants/food purchase venues (*attach a second sheet if needed*):

Restaurant Name	Location (street address and city/village)	Date visited	Items ordered	Other dining partners?	Other dining partners ill?

Did the case attend any social events (parties, weddings, etc.) where he/she ate fish during the exposure period?

Yes No Unk

If yes, complete the following (*attach a second sheet if needed*):

Event Name	Location (Where it was held)	Event Date	Items eaten	Other dining partners?	Other dining partners ill?

SUMMARY

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

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