



BC Cholera Follow-up Form

Demographic and Contact Information

Patient Surname:		First Name:	PHN:
Birthdate: (e.g. 15/Dec/07)	Sex: F <input type="checkbox"/> M <input type="checkbox"/>	Parent or Guardian: <input type="checkbox"/> Respondent is case	
Address: (street, city, postal code)		Home phone: _____	
E-mail:		Work: _____	
Physician:		Cell: _____	
		Physician Phone: _____	

Case Notification/Assignment

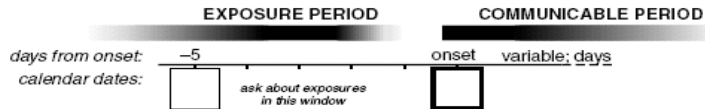
Report Received at HU: (e.g. 15/Dec/07)	
Contact attempts (date and time)	Interview?
1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>
Interviewer: <input type="checkbox"/> Not located	

Clinical Information

Species: <input type="checkbox"/> 01/0139 <input type="checkbox"/> non-01/0139 If 01/0139: <input type="checkbox"/> Inaba <input type="checkbox"/> Ogawa <input type="checkbox"/> Hikojima <input type="checkbox"/> Unknown	Specimen type:	Lab Report Date: (e.g. 15/Dec/07)	Reporting lab:
Onset of Earliest Symptom (e.g. 15/Dec/07) Time: _____ am/pm	Earliest Symptom:	Hospitalized: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Name of Hospital:
Other Symptoms: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea Other: _____ <input type="checkbox"/> Rice water stool <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Fever Other: _____	Date of Admission (e.g. 15/Dec/07):	Date of Discharge (e.g. 15/Dec/07):	Antibiotic use: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK
	Deceased: <input type="checkbox"/> Y <input type="checkbox"/> N		

Exposure Period

Enter onset date in heavy box.
Count back to figure the probable exposure period.



Travel

Infection acquired during travel: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK If yes: <input type="checkbox"/> Within BC <input type="checkbox"/> Within Canada <input type="checkbox"/> Outside Canada
Departure (e.g. 15/Dec/07): Return (e.g. 15/Dec/07): Destination(s) (e.g. city, mode of travel): Foods brought back?:
Oral cholera vaccine received within 6 months: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK IV cholera vaccine received within 6 months: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK

Specific High Risk Foods/Activities

Risk factor		Details	Risk factor		Details
Fish	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Shrimp	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw?
Sushi	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK		Oysters	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw?
Mussels	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw?	Ocean water (swimming, etc)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Clams	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw?	Brackish water (i.e. estuaries)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Crab	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw?	Preexisting wound	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	
Lobster	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK	Raw?			

Local Shellfish Source (if applicable)

<input type="checkbox"/> Restaurant <input type="checkbox"/> Store/Market	<input type="checkbox"/> Self Harvested
Restaurant/Store/Market Name	Location of harvesting:
Date purchased (e.g. 15/Dec/07):	Date harvested (e.g. 15/Dec/07):
Address: _____	City: _____
Shellfish Supplier, Tag #:	

