BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Vibrio cholerae Infection Case Report Form

Confidential when completed

PERSON REPORTING	
Health Authority:	☐ FHA ☐ IHA ☐ VIHA ☐ NHA ☐ VCH
Name:	*Last* *First*
Phone:	( ) - ext.
Email:	

Date Report Received at HU (YYYY/MM/DD): _____

Contact attempts (date and time)	*Interview?*
1.	☐
2.	☐
3.	☐
4.	☐

Interviewer: ☐ *Not located*

A. CLIENT INFORMATION

Name: *Last* *First* *Middle* Alternate Name(s):

PHN: | Date of Birth: *YYYY / MM / DD* | Sex: ☐ Male ☐ Female

Home Address: *Unit #* *Street #* *Street Name* | City:

Postal code: | Province: | Phone number (home/office/cell) ( ) - ext.

Email: | Physician Name *Last* *First* | Physician Phone Number:

Interview conducted with:

B. ABORIGINAL INFORMATION

Do you wish to self-identify as an Aboriginal Person?
☐ Asked, not provided ☐ No
☐ Not asked ☐ Yes

Aboriginal Identity:
☐ Asked, but unknown ☐ Asked, not provided ☐ First Nations
☐ First Nations and Inuit ☐ First Nations and Métis ☐ First Nations, Inuit and Métis ☐ Inuit
☐ Inuit and Métis ☐ Métis ☐ Not asked

First Nations Status:
☐ Asked, but unknown ☐ Asked, not provided ☐ Non-Status Indian
☐ Not Asked ☐ Status Indian

C. CLINICAL INFORMATION

Date of onset of symptoms: _____ *YYYY / MM / DD* Onset time: _____ AM / PM

Signs and Symptoms Earliest symptom: _____

Other Symptoms:
☐ Abdominal discomfort ☐ Shock (circulatory) ☐ Dehydration ☐ Diarrhea
☐ Diarrhea - rice water stool ☐ Fever ☐ Kidney failure ☐ Liver failure ☐ Nausea
☐ Vomiting ☐ Other: _____

Hospitalization Admitted to hospital: ☐ Yes ☐ No ☐ Unknown Hospital name: _____
Admission date: _____ *YYYY / MM / DD* Discharge date: _____ *YYYY / MM / DD*

Immunization Status
Oral cholera vaccine received within 6 months: ☐ Yes ☐ No ☐ Unknown
IV cholera vaccine received within 6 months: ☐ Yes ☐ No ☐ Unknown

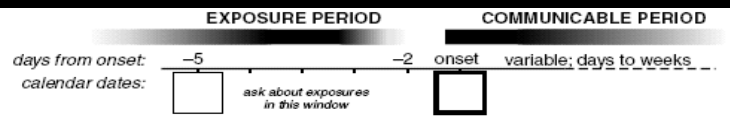
Outcome Death: ☐ Yes ☐ No ☐ Unknown *If yes*, death date: _____ *YYYY / MM / DD*

D. LABORATORY INFORMATION

Specimen Type	Reporting Lab	Collection Date	Result
		YYYY / MM / DD	Serogroup: ☐ O1/O139 ☐ non-O1/O139 If O1/O139: ☐ Inaba ☐ Ogawa ☐ Hikojima ☐ Unknown

E. EXPOSURE INFORMATION

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



Travel

Travel during exposure period: ☐ Yes ☐ No ☐ U *If Yes:* ☐ within BC ☐ outside BC but within Canada ☐ outside Canada

Was travel confirmed as the most likely source of infection? ☐ Yes **NOTE:** *For V. cholera* O1/O139, travel to an endemic area during *any* part of the exposure period or travel outside HA of residence during the *entire* exposure period is considered confirmed travel-related.

Dates: DEPARTURE	Dates: RETURN	Locations (e.g., city, country, resort)	Additional detail	Foods brought back
YYYY / MM / DD	YYYY / MM / DD			

Foods and Activities

Food	Exposed	Details	Food/Exposure	Exposed	Details
Fish	☐ Yes ☐ No ☐ U		Shrimp	☐ Yes ☐ No ☐ U	☐ Raw
Sushi	☐ Yes ☐ No ☐ U		Oysters	☐ Yes ☐ No ☐ U	☐ Raw
Mussels	☐ Yes ☐ No ☐ U	☐ Raw	Ocean water (swimming etc.)	☐ Yes ☐ No ☐ U	
Clams	☐ Yes ☐ No ☐ U	☐ Raw	Brackish water (i.e., estuaries)	☐ Yes ☐ No ☐ U	
Crab	☐ Yes ☐ No ☐ U	☐ Raw	Pre-existing wound	☐ Yes ☐ No ☐ U	
Lobster	☐ Yes ☐ No ☐ U	☐ Raw			

*If consumed **local shellfish***:*

Source		Tag/invoice Information:
☐ Restaurant ☐ Store/Market **Name:** **Address:** **Date purchased:** (YYYY/MM/DD)	☐ Self-harvest **Location:** **Date harvested:** (YYYY/MM/DD)	☐ Attached ☐ To follow ☐ Not available

* ***If client consumed bivalve shellfish purchased from a restaurant or store in British Columbia, email or fax all pages and tags to:*** BCCDC, attn. Enteric Epi, ezvbepi@bccdc.ca or 604-707-2516.

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F. CONTACTS

people in household:

Name	Date ill *YYYY/MM/DD*	Nature of contact*	Occupation/Details	Contact phone	^Excluded?

** Household, sexual, close contacts, other*
^ Please complete Contact Exclusion Form for each contact excluded.

G. OCCUPATION AND EXCLUSION

Occupation:

Sensitive Setting (check if applicable):

- ☐ Work/volunteer or attend day care
- ☐ Work/volunteer in a health care setting
- ☐ Work/volunteer as a food handler
- ☐ Other (e.g. pool): _____

Facility name:

Excluded ☐Y ☐N Effective date *(YYYY/MM/DD)*:

Details:

Symptom end date *(YYYY/MM/DD)*:

Exclusion lifted *(YYYY/MM/DD)*: MHO:

H. CASE EXCLUSION WORKSHEET *

Antibiotic Use: ☐ Yes ☐ No ☐ Unknown

Length of treatment: _____ days

Date of Discontinuation *(YYYY/MM/DD)*: _____

Sample No.	Date *(YYYY/MM/DD)*	Result	Notes
1		☐ Pos ☐ Neg	
2		☐ Pos ☐ Neg	
3		☐ Pos ☐ Neg	
4		☐ Pos ☐ Neg	

* Refer to CD Control Guidelines on Exclusion of Enteric Cases and their Contacts from High Risk Settings

I. INTERVENTIONS

Type	Implemented	Details	Type	Implemented	Details
Referred for Inspection	☐		Health File Sent	☐	
Hygiene Education	☐		Other:	☐	
Referred to another HA	☐				

J. NOTES

Date	Comment	Initials