North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

CRYPTOSPORIDIOSIS

Confidential Communicable Disease Report—Part 2

NC DISEASE CODE: 56

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

ATTENTION Local Health Department Staff: There is no Part 2 Wizard for this disease. Enter all information from this form into the NC EDSS question packages.

If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

NC EDSS LAB RESULTS — Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

CLINICAL FINDINGS

Is/was patient symptomatic for this disease? ☐ Y ☐ N ☐ U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
Fever ☐ Y ☐ N ☐ U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature__________
Fever onset date (mm/dd/yyyy): ____/____/____
Loss of appetite (anorexia) ☐ Y ☐ N ☐ U
Weight loss with illness ☐ Y ☐ N ☐ U
Nausea ☐ Y ☐ N ☐ U
Vomiting ☐ Y ☐ N ☐ U
Abdominal pain or cramps ☐ Y ☐ N ☐ U
Diarrhea ☐ Y ☐ N ☐ U
Maximum number of stools in a 24-hour period:_____
Other symptoms, signs, clinical findings, or complications consistent with this illness ☐ Y ☐ N ☐ U
Specify: ______________________

PREDISPOSING CONDITIONS

HIV/AIDS ☐ Y ☐ N ☐ U
Any immunosuppressive conditions (other than HIV/AIDS) ☐ Y ☐ N ☐ U
Please specify: ______________________
Malignancy ☐ Y ☐ N ☐ U
Receiving treatment or taking any medications ☐ Y ☐ N ☐ U
☐ Chemotherapy
☐ Immunosuppressive therapy, including anti-rejection therapy
☐ Radiotherapy
☐ Systemic steroids/corticosteroids, including steroids taken by mouth or injection

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐ Y ☐ N ☐ U
Hospital name: ______________________
City, State: ______________________
Hospital contact name: ______________________
Telephone: (______) ______ - __________
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy): ____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) ☐ Y ☐ N
If yes, specify: ______________________
____

CLINICAL OUTCOMES

Discharge/Final diagnosis: ______________________
____
Survived? ☐ Y ☐ N ☐ U
Died? ☐ Y ☐ N ☐ U
Died from this illness? ☐ Y ☐ N ☐ U
Date of death (mm/dd/yyyy):_____/_____/_____
Autopsy performed? ☐ Y ☐ N ☐ U
Patient autopsied in NC? ☐ Y ☐ N ☐ U
County of autopsy: ______________________
Autopsied outside NC, specify where: ______________________
Source of death information (select all that apply):
☐ Death certificate
☐ Autopsy report final conclusions
☐ Hospital/discharge physician summary
☐ Other

TRAVEL/IMMIGRATION

The patient is:
☐ Resident of North Carolina
☐ Resident of another state or US territory
☐ None of the above
Did patient travel during the 12 days prior to onset of symptoms? ☐ Y ☐ N ☐ U
List travel dates and destinations:
From _____/_____/_____ to _____/_____/_____
____
____
Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐ Y ☐ N ☐ U
Name: ______________________
Additional travel/residency information:

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? .... ☐ Y ☐ N ☐ U

Name of care provider: ________________________

Address: ________________________

City: ____________ State: ________

Zip code: ________ County: ____________

Contact name: ________________________

Telephone: (_______) ________________________

Patient wears diapers or shares a classroom with diapered children? .... ☐ Y ☐ N ☐

Who wears diapers?

☐ Patient ☐ Classmate

Give names of all child health care arrangements attended by the patient that involve diapering (patient wears diapers or other children in the same group wear diapers).

____

____

Patient a child care worker or volunteer in child care? .... ☐ Y ☐ N ☐ U

Name of child care provider: ________________________

Address: ________________________

City: ____________ State: ________

Zip code: ________ County: ____________

Contact name: ________________________

Telephone: (_______) ________________________

Patient a parent or primary caregiver of a child in child care? .... ☐ Y ☐ N ☐ U

Name of child care provider: ________________________

Address: ________________________

City: ____________ State: ________

Zip code: ________ County: ____________

Contact name: ________________________

Telephone: (_______) ________________________

Notes:

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 12 days prior to onset of symptoms, did the patient have exposure to a diapered or incontinent child or adult? .... ☐ Y ☐ N ☐ U

Nature of exposure ________________________

Other exposures? .... ☐ Y ☐ N ☐ U

Specify ________________________

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? .... ☐ Y ☐ N ☐ U

If yes, specify:

During the 12 days prior to onset of symptoms, did the patient have contact with sewage or human excreta? .... ☐ Y ☐ N ☐ U

FOOD RISK AND EXPOSURE

During the 12 days prior to onset of symptoms, did the patient eat any raw or undercooked seafood or shellfish (i.e., raw oysters, sushi, etc.)? .... ☐ Y ☐ N ☐ U

Specify type of seafood/shellfish ________________

Specify place of exposure ________________

Did the patient drink any bottled water? .... ☐ Y ☐ N ☐ U

Specify type/brand: ________________________

Describe the source of drinking water used in the patient's home (check all that apply)**:**

☐ Bottled water supplied by a company

☐ Bottled water purchased from a grocery store

☐ Municipal supply (city water)

☐ Well water

Where does the patient/patient's family typically buy groceries?

Store name: ________________________

Store city: ________________________

Shopping center name/address:

____

During the 12 days prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? .... ☐ Y ☐ N ☐ U

Specify source: ________________________

Eat any food items that came from a store or vendor where they do not typically shop for groceries? .... ☐ Y ☐ N ☐ U

Specify source(s): ________________________

During the 12 days prior to onset of symptoms, was the patient:

Employed as food worker? .... ☐ Y ☐ N ☐ U

Where employed? ________________________

Specify job duties: ________________________

What dates did the patient work?

____

Employed as food worker while symptomatic? .... ☐ Y ☐ N ☐ U

Where did the patient work? ________________

What dates did the patient work?

____

What day did the patient return to food service work?

Date: ________________________

Where did patient return to work? ____________

Non-occupational food worker?

(e.g. potlucks, receptions) during contagious period............................ ☐ Y ☐ N ☐ U

Where employed? ________________________

Specify dates worked during contagious period:

____

Comments:

Health care worker or child care worker handling food or medication in the contagious period ? .... ☐ Y ☐ N ☐ U

Where employed? ________________________

Specify dates worked during contagious period:

____

Comments:

CONTINUED ON NEXT PAGE

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

FOOD RISK AND EXPOSURE (CONTINUED)

During the 12 days prior to onset of symptoms, did the patient:

Drink unpasteurized milk?............... ☐ Y ☐ N ☐ U

Specify type of milk:
- ☐ Cow
- ☐ Goat
- ☐ Sheep
- ☐ Other, specify: ____________
- ☐ Unknown

Eat any other unpasteurized dairy products?.............................. ☐ Y ☐ N ☐ U

Specify type of product:
- ☐ Queso fresco, Queso blanco or other Mexican soft cheese
- ☐ Butter
- ☐ Cheese from raw milk, specify:____________
- ☐ Food made from raw dairy product, specify:____________
- ☐ Other, specify: ____________

Drink unpasteurized juices or ciders?. ☐ Y ☐ N ☐ U

Specify juices or ciders:
- ☐ Apple
- ☐ Orange
- ☐ Other, specify: ____________

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)**?**................................ ☐ Y ☐ N ☐ U

Handle/eat clams? .... ☐ Y ☐ N ☐ U
Handle/eat crabs?............................ ☐ Y ☐ N ☐ U
Handle/eat lobster?.......................... ☐ Y ☐ N ☐ U
Handle/eat mussels?........................ ☐ Y ☐ N ☐ U
Handle/eat oysters?......................... ☐ Y ☐ N ☐ U
Handle/eat shrimp?.......................... ☐ Y ☐ N ☐ U
Handle/eat crawfish?........................ ☐ Y ☐ N ☐ U
Handle/eat other shellfish?............... ☐ Y ☐ N ☐ U

Eat raw fruit?.................................... ☐ Y ☐ N ☐ U

Specify raw fruit:
- ☐ Apples
- ☐ Bananas
- ☐ Oranges
- ☐ Grapes, specify:__________
- ☐ Pears
- ☐ Peaches
- ☐ Berries, specify__________
- ☐ Melon,specify__________
- ☐ Mangoes
- ☐ Other, specify: __________

Eat raw salads or vegetables other than sprouts?.......................... ☐ Y ☐ N ☐ U

Specify raw salad or vegetable:
- ☐ Bagged salad greens without toppings, type: ____________
- ☐ Salad with toppings, specify: ____________
- ☐ Lettuce, type: ____________
- ☐ Spinach
- ☐ Tomatoes, type: __________
- ☐ Cucumbers
- ☐ Mushrooms, type: __________
- ☐ Onions, type: __________
- ☐ Potatoes, type:__________
- ☐ Other, specify: __________

Eat sprouts?..................................... ☐ Y ☐ N ☐ U

Specify type of sprouts:
- ☐ Alfalfa ☐ Clover ☐ Bean
- ☐ Other, specify: __________
- ☐ Unknown

Eat fresh herbs? .... ☐ Y ☐ N ☐ U

Specify:
- ☐ Basil
- ☐ Parsley
- ☐ Oregano
- ☐ Cumin
- ☐ Thyme
- ☐ Cilantro
- ☐ Rosemary
- ☐ Other, specify: ____________

WATER EXPOSURE

During the 12 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water (including community or health care settings? .... ☐ Y ☐ N ☐ U

Activity(ies): ____________

Type(s) of water:
- ☐ Freshwater (stream, river, pond, lake, pool)
- ☐ Estuarine or marine water (brackish or salt water sound, estuary, ocean)

On (mm/dd/yyyy)____________

Until (mm/dd/yyyy) ____________

Frequency
- ☐ Once
- ☐ Multiple times within this time period
- ☐ Daily

Route of exposure (agent entry) for recreational exposure (check all that apply):
- ☐ Accidental ingestion
- ☐ Intentional ingestion
- ☐ Other
- ☐ Unknown

Water source(s) / setting(s) (select all sources and settings that apply):
- ☐ Spring/hot spring
- ☐ River, stream
- ☐ Lake, pond, reservoir
- ☐ Estuary/tidal area (brackish/salty water)
- ☐ Ocean
- ☐ Pool
- ☐ Fountain
- ☐ Hot tub
- ☐ Whirlpool/spa pool
- ☐ Other
- ☐ Unknown

Factors contributing to water contamination
- ☐ High bather density / load
- ☐ Fecal accident by bather(s)
- ☐ Use by diapered / toddler-aged children
- ☐ Overflow or release of sewage (observed or signage)
- ☐ Flooding / heavy rains
- ☐ Stagnant water
- ☐ Water temperature >= 30 C (86 F)
- ☐ Chemical pollution
- ☐ Algal bloom
- ☐ Animal feces observed near site
- ☐ Agricultural / animal production in watershed
- ☐ Unprotected watershed
- ☐ Other
- ☐ Unknown

Was water treatment of source or setting provided?.............................. ☐ Y ☐ N ☐ U

Please specify water treatment(s) (check all that apply):
- ☐ Settling (sedimentation)
- ☐ Coagulation and / or flocculation
- ☐ Filtration at purification plant (not including home filters)
- ☐ Disinfection
- ☐ Other
- ☐ Unknown

Specify type of water filtration method used:

Specify type of water disinfection used:

OUTDOOR EXPOSURE

During the 12 days prior to onset of symptoms, did the patient participate in any outdoor activities?... ☐ Y ☐ N ☐ U

If yes, specify and give details:

What was location of the exposure?
- ☐ North Carolina
  County ____________
- ☐ US (not North Carolina)
  State____________
- ☐ Foreign
  Country____________

Did patient skin/eviscerate (gut) wild animal or have contact with wild animal carcass? ☐ Y ☐ N ☐ U

Please specify animal(s): ____________

ANIMAL EXPOSURE

During the 12 days prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)**?** .... ☐ Y ☐ N ☐ U

If yes, specify and give details:

Household pets?............................... ☐ Y ☐ N ☐ U

Specify:

Did patient own, work at, or visit a pet store, animal shelter, and/or animal breeder/wholesaler/ distributor?.. ☐ Y ☐ N ☐ U

If yes, specify and give details:

Did patient handle any animals? .... ☐ Y ☐ N ☐ U

Species:

Did it/they appear sick? .... ☐ Y ☐ N ☐ U

Did patient work with animal importation? .... ☐ Y ☐ N ☐ U

If yes, specify and give details:

Did patient / household contact work at, live on, or visit a farm, ranch, or dairy? .... ☐ Y ☐ N ☐ U

If yes, specify and give details:

Was patient exposed to animals associated with agriculture or aviculture (domestic/semi-domestic animals)? .... ☐ Y ☐ N ☐ U

If yes, specify and give details:

CONTINUED ON NEXT PAGE

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN

ANIMAL EXPOSURE (CONTINUED)

During the 12 days prior to onset of symptoms, did the patient:

Have exposure to animal excreta (urine or feces)**?** ☐ Y ☐ N ☐ U
If yes, specify and give details:

Work at or visit a slaughterhouse (abattoir), meat-packing plant, poultry or wild game processing facility? ☐ Y ☐ N ☐ U
If yes, specify and give details:

Has patient otherwise slaughtered animals or been a butcher, meat cutter, or meat processor? ☐ Y ☐ N ☐ U
If yes, specify and give details:

Did the patient work at or visit a fair with livestock or a petting zoo? ☐ Y ☐ N ☐ U
If yes, specify and give details:

Did the patient work at or visit a zoo, zoological park, or aquarium? ☐ Y ☐ N ☐ U
If yes, specify and give details:

Did patient own, work at, or visit a private or public aviary (bird exhibit) or live bird market? ☐ Y ☐ N ☐ U
If yes, specify and give details:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐ Y ☐ N ☐ U
Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others? ☐ Y ☐ N ☐ U
Who was interviewed?

Were health care providers consulted? ☐ Y ☐ N ☐ U
Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ☐ Y ☐ N ☐ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC
City ____________________
County____________________

☐ Outside NC, but within US
City ____________________
State ____________________
County____________________

☐ Outside US
City ____________________
Country ____________________

☐ Unknown

Is the patient part of an outbreak of this disease? ☐ Y ☐ N

Notes regarding setting of exposure:

Cryptosporidiosis *(Cryptosporidium)*

2009 Case Definition

Clinical description

An illness characterized by watery diarrhea, abdominal cramps, loss of appetite, low-grade fever, nausea and vomiting. The disease can be prolonged and life-threatening in severely immunocompromised persons.

Laboratory criteria for diagnosis

Laboratory-confirmed cryptosporidiosis shall be defined as the detection of a member of the genus *Cryptosporidium* by one of the following methods:

1. Organisms in stool, intestinal fluid, or tissue samples or biopsy specimens
2. in intestinal fluid or small-bowel biopsy specimens, or
3. Antigens in stool or intestinal fluid, or
4. Nucleic acid by PCR in stool, intestinal fluid, or tissue samples or biopsy specimens

Case classification

Confirmed: a case that meets the clinical description and at least one of the criteria for laboratory-confirmation as described above. When available, species designation and molecular characterization should be reported.

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