

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



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

CYCLOSPORIASIS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 63

REMINDER to Local Health Department staff: 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



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
/ /						/ /	
/ /						/ /	
/ /						/ /	



Is/was patient symptomatic for this disease? Y N U
If yes, symptom onset date (mm/dd/yyyy): ___/___/___
CHECK ALL THAT APPLY:
Fever Y N U
 Yes, subjective No
 Yes, measured Unknown
 Highest measured temperature _____
 Fever onset date (mm/dd/yyyy): ___/___/___
Fatigue or malaise or weakness Y N U
Loss of appetite Y N U
Weight loss with illness Y N U
Muscle aches/pains (myalgias) Y N U
Nausea Y N U
Vomiting Y N U
Bloating or gas Y N U
Abdominal pain or cramps Y N U
Constipation Y N U
Diarrhea Y N U
 Describe (select all that apply)
 Bloody Watery
 Non-bloody Other _____
 Maximum number of stools in a 24-hour period: _____
Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U
 Please specify: _____

PREDISPOSING CONDITIONS

Any immunosuppressive conditions Y N U
 Please specify: _____

REASON FOR TESTING

Why was the patient tested for this condition?
 Symptomatic of disease
 Screening of asymptomatic person with reported risk factor(s)
 Exposed to organism causing this disease (asymptomatic)
 Household / close contact to a person reported with this disease
 Other, specify _____
 Unknown

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? 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): ___/___/___

TRAVEL/IMMIGRATION

The patient is:
 Resident of North Carolina
 Resident of another state or US territory
 None of the above
Did patient have a travel history during the 14 days prior to onset of symptoms? Y N U
 Travel dates: From: _____ until _____
 To city: _____
 To country: _____
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 / /

BEHAVIORAL RISK & CONGREGATE LIVING

During the 14 days prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U

Name of facility: _____

Dates of contact: _____

During the 14 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? Y N U

If yes, specify: _____

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

OTHER EXPOSURE INFORMATION

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

If yes, specify: _____

FOOD RISK AND EXPOSURE

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

Does the patient have a water softener or water filter installed inside the house to treat their water? Y N U

During the 14 days prior to onset of symptoms, did the patient drink any bottled water? Y N U

Specify type/brand: _____

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

Store name: _____

Store city: _____

Shopping center name/address: _____

During the 14 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): _____

FOOD RISK AND EXPOSURE (continued)

During the 14 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

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 Thyme

Parsley Cilantro

Oregano Rosemary

Cumin

Other, specify: _____

Eat at a group meal? Y N U

Specify:

Place of Worship

School

Social function

Other, Specify: _____

Eat food from a restaurant? Y N U

Name: _____

Location: _____

WATER EXPOSURE

During the 14 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water, including aerosolized water in household, community or health care settings? Y N U

If yes, describe in detail giving type of activity, water, route of exposure, water sources, factors contributing to water contamination, and any water treatment methods:

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:

Cyclosporiasis (*Cyclospora cayetanensis*)

1998 CDC Case Definition

Clinical description

An illness of variable severity caused by the protozoan *Cyclospora cayetanensis* and commonly characterized by watery diarrhea, loss of appetite, weight loss, abdominal bloating and cramping, increased flatus, nausea, fatigue, and low-grade fever. Vomiting also may be noted. Relapses and asymptomatic infections can occur.

Laboratory criteria for diagnosis

Laboratory-confirmed cyclosporiasis shall be defined as the detection—in symptomatic or asymptomatic persons—of *Cyclospora*

1. oocysts in stool by microscopic examination, or
2. in intestinal fluid or small bowel biopsy specimens, or
3. demonstration of sporulation, or
4. DNA (by polymerase chain reaction) in stool, duodenal/jejunal aspirates or small bowel biopsy specimens.

Case classification

Confirmed, symptomatic: a laboratory-confirmed case associated with one of the symptoms described above

Confirmed, asymptomatic: a laboratory-confirmed case associated with none of the above symptoms