WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Giardiasis

PATIENT DEMOGRAPHICS

Name (last, first): _____
Address (mailing): _____
Address (physical): _____
City/State/Zip: _____
Phone (home): _____ **Phone** (work/cell) : _____

Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
Name: _____ *Phone:* _____

***Birth date**: __ / __ / ____ **Age**: _____
***Sex**: ☐Male ☐Female ☐Unk

***Ethnicity**: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

***Race**: (Mark all that apply) ☐ White ☐Black/Afr. Amer. ☐ Native HI/Other PI ☐ Am. Ind/AK Native ☐ Asian ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____
Investigation Start Date: __ / __ / ____
Earliest date reported to LHD: __ / __ / ____
Date sent for Regional Review: __ / __ / ____

Case Classification:
☐ Confirmed ☐ Probable ☐ Suspect
☐ Not a case ☐ Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐Private Provider ☐Public Health Agency ☐Other
Reporter Name: _____ Reporter Phone: _____
Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

Onset date: __ / __ / ____ **Diagnosis date**: __ / __ / ____ **Recovery date**: __ / __ / ____

Clinical Findings

Y	N	U	
☐	☐	☐	Diarrhea
☐	☐	☐	Pale, greasy stool
☐	☐	☐	Bloating or excess gas
☐	☐	☐	Weight loss with illness
☐	☐	☐	Abdominal cramps
☐	☐	☐	Constipation

*Hospitalization

Y	N	U	
☐	☐	☐	Hospitalized for this illness

Hospital name: _____
Admit date: __ / __ / ____ Discharge date: __ / __ / ____

*Death

Y	N	U	
☐	☐	☐	Died due to this illness

Date of death: __ / __ / ____

LABORATORY (Please submit copies of all labs associated with this illness to DIDE)

Specimen source: _____

Collection date: __ / __ / ____

Y	N	U	
☐	☐	☐	G. lamblia cysts (O&P)
☐	☐	☐	G. lamblia trophozoites (stool, duodenal fluid, small bowel biopsy
☐	☐	☐	G. lamblia antigen by immunodiagnostic test such as EIA

Notes (clinical/laboratory)

INFECTION TIMELINE

Instructions:
Enter onset date in grey box. Count backward to determine probable exposure period

	Exposure period		Onset date
Days from onset	***-14 (Max Incubation)***	***-7 (Min Incubation)***	
Calendar dates:	__ / __ / ____	__ / __ / ____	__ / __ / ____

EPIDEMIOLOGIC EXPOSURES (Unless otherwise stated, questions refer to the exposure period calculated above.)

Y N U

- ☐ ☐ ☐ *Drink untreated/unchlorinated water (i.e. surface, well)?
- ☐ ☐ ☐ *Hike, camp, fish or swim? If yes, where_____
- ☐ ☐ ☐ *Other recreational water exposures?
- ☐ ☐ ☐ Visit a petting zoo, farm or pet shop? Where_____
- ☐ ☐ ☐ Exposure to pets? If yes, was pet sick? **Yes / No**
- ☐ ☐ ☐ *Travel to another state or country? If yes, where _____

Is case member of a high risk occupation?
(Mark One)

- ☐ Food Handler
- ☐ Health Care Worker
- ☐ Day Care Worker/Attendee
- ☐ Student
- ☐ None of Above

Employer/School Name**:** _____

Attend any group activitites, parties or gatherings? **Yes / No** If yes, list

Date	Activity	Location

PUBLIC HEALTH ISSUES

If any household member is symptomatic, the member is epi-linked and therefore is a probable case and should be investigated further. A stool sample for parasites (O&P) and disease case report should be completed**.**

Name	Relationship to Case	Onset Date	Lab Testing

Y N NA

- ☐ ☐ ☐ Employed as food handler
- ☐ ☐ ☐ Non-occupational food handling (e.g. pot lucks, receptions)
- ☐ ☐ ☐ Attends or employed in child care
- ☐ ☐ ☐ Household member or close contact in sensitive occupation (food, HCW, child care)
- ☐ ☐ ☐ Case is part of an outbreak
  Outbreak Name:_____

PUBLIC HEALTH ACTIONS

Y N NA

- ☐ ☐ ☐ Disease/Transmission Education Provided
- ☐ ☐ ☐ Exclude individuals in sensitive Occupations(food, HCW, child care)
- ☐ ☐ ☐ Restaurant inspection
- ☐ ☐ ☐ Child care inspection
- ☐ ☐ ☐ Culture symptomatic contacts
- ☐ ☐ ☐ Well or water testing performed
- ☐ ☐ ☐ Patient is lost to follow up
- ☐ ☐ ☐ Other:_____

NOTES