West Virginia Bureau for Public Health — Your Health Your Safety Our Purpose
Department of Health & Human Resources

Vibriosis (non-cholera species)

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: __ / __ / ____
Earliest date reported to State: __ / __ / ____

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
☐	☐	☐	Bloody stool
☐	☐	☐	Fever highest temp_____
☐	☐	☐	Vomiting
☐	☐	☐	Nausea
☐	☐	☐	Abdominal cramps
☐	☐	☐	Headache
☐	☐	☐	Muscle pain
☐	☐	☐	Cellulitis
☐	☐	☐	Bullae
☐	☐	☐	Shock (systolic BP <90)

Clinical Risk Factors (30 days prior to onset)

Did patient receive…? If yes, specify type and date

☐	☐	☐	Antibiotics	_____
☐	☐	☐	Chemotherapy	_____
☐	☐	☐	Radiotherapy	_____
☐	☐	☐	Systemic steroids	_____
☐	☐	☐	Immunosuppressants	_____
☐	☐	☐	Antacids	_____
☐	☐	☐	H_2 blocker or other ulcer medication	_____

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: __ / __ / ____

Pre-Existing Conditions

				Y	N	U
☐	☐	☐	Alcoholism			
☐	☐	☐	Diabetes; If yes, on insulin?	☐	☐	☐
☐	☐	☐	Heart disease			
☐	☐	☐	Peptic ulcer			
☐	☐	☐	Gastric surgery	type:_____		
☐	☐	☐	Hematologic disease	type:_____		
☐	☐	☐	Immunodeficiency	type:_____		
☐	☐	☐	Liver disease	type:_____		
☐	☐	☐	Malignancy	type:_____		
☐	☐	☐	Renal Disease	type:_____		

TREATMENT

Y	N	U	
☐	☐	☐	Patient received antibiotic therapy due to this infection

If yes, specify:
Type:_____ Date started: __/__/____ Date ended: __/__/____

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

Specimen source: ☐Stool ☐Urine ☐Blood ☐Other _____ Collection date: __ / __ / ____

Y	N	U	
☐	☐	☐	Culture positive for *Vibrio* species
			☐ *V. parahaemolyticus* ☐ *V. vulnificus* ☐ Other *Vibrio spp*. Specify: _____
☐	☐	☐	Isolate submitted to state public health lab (OLS)

INFECTION TIMELINE

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

	Exposure period		Onset date
Days from onset	***-7 (Max Incubation)***	***-1 (Min Incubation)***	
Calendar dates:	__ / __ / ____	__ / __ / ____	__ / __ / ____

EPIDEMIOLOGIC EXPOSURES

Did the patient consume any of the following seafood? If yes, provide place and date of consumption. (If multiple times, most recent meal)

Y N U		Circle cooking method:							Date	Place
☐ ☐ ☐	Clams	Raw	Baked	Boiled	Broiled	Fried	Steamed	Unk	__/__/____	_____
☐ ☐ ☐	Crab	Raw	Baked	Boiled	Broiled	Fried	Steamed	Unk	__/__/____	_____
☐ ☐ ☐	Lobster	Raw	Baked	Boiled	Broiled	Fried	Steamed	Unk	__/__/____	_____
☐ ☐ ☐	Mussels	Raw	Baked	Boiled	Broiled	Fried	Steamed	Unk	__/__/____	_____
☐ ☐ ☐	Oysters	Raw	Baked	Boiled	Broiled	Fried	Steamed	Unk	__/__/____	_____
☐ ☐ ☐	Shrimp	Raw	Baked	Boiled	Broiled	Fried	Steamed	Unk	__/__/____	_____
☐ ☐ ☐	Crawfish	Raw	Baked	Boiled	Broiled	Fried	Steamed	Unk	__/__/____	_____

Travel or stay overnight somewhere outside West Virginia? Y ☐ N ☐ U ☐

If yes, give destination and dates.

City	Date Arrived	Date Left

Was patient's skin exposed to any of the following: If yes, specify location, date and time of water exposure

- ☐ ☐ ☐ Fresh water
- ☐ ☐ ☐ Salt water
- ☐ ☐ ☐ Brackish water
- ☐ ☐ ☐ Drippings from raw or live seafood
- ☐ ☐ ☐ Other contact with marine or freshwater life

Body of water location: _____

Date of water exposure: ___/___/____

If yes to any of the above, did or was patient:

- ☐ ☐ ☐ Handle/clean seafood
- ☐ ☐ ☐ Swimming/diving/wading
- ☐ ☐ ☐ Walk on beach/shore/fell on rocks/shells
- ☐ ☐ ☐ Boating/skiing/surfing
- ☐ ☐ ☐ Sustain a wound during this exposure
- ☐ ☐ ☐ Have a pre-existing wound?
- ☐ ☐ ☐ Construction/repairs
- ☐ ☐ ☐ Bitten/stung

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 culture and disease case report should be completed.

Name	Relationship to Case	Onset Date	Lab Testing

Y N NA

- ☐ ☐ ☐ Consumed shellfish from a WV location (must obtain shellfish tags)
- ☐ ☐ ☐ Consumed shellfish from another state
- ☐ ☐ ☐ Case is part of an outbreak

Outbreak Name or Number_____

PUBLIC HEALTH ACTIONS

Y N NA

- ☐ ☐ ☐ Disease/Transmission Education Provided
- ☐ ☐ ☐ Notified DIDE of shellfish from another state
- ☐ ☐ ☐ Restaurant inspection/obtained tags
- ☐ ☐ ☐ Culture symptomatic contacts
- ☐ ☐ ☐ Patient is lost to follow up
- ☐ ☐ ☐ Other:_____