### GIARDIASIS CASE INVESTIGATION FORM

Use this form to determine case status of reported cases and to interview confirmed and probable cases of giardiasis. Please be sure to enter questions marked with an * into CEDRS to assist with determining case status for all reported cases.

<table>
<thead>
<tr>
<th>Patient Name: _______________________</th>
<th>CEDRS # __________</th>
<th>Interview date: <strong><strong>/</strong></strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency Name: _________________________</td>
<td>Form Completed by: ________________________</td>
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<tr>
<td>Person interviewed: Case Other (circle: Parent Spouse Household member Friend Physician)</td>
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#### Demographics and Contact Information

**Date of Birth ____/____/______ Age: _____ (Circle: Yrs., Mos., Days) Sex: F M**

**Race (Circle all that apply):**
- American Indian/Alaska Native
- Pacific Islander/Hawaiian Native
- Asian
- Black
- White
- Other
- Unknown

**Ethnicity (Circle one):**
- Hispanic
- Non Hispanic
- Unknown

Language spoken: ____________________________

Parent/legal guardian: _______________________

**Residence:**

Address: ________________________________

City: ____________________________

County: ____________________________

Zip Code: __________

**Phone Numbers:**

Home Phone: (____)_______________

Work Phone: (____)_______________

Pager: (____)_______________

Mobile: (____)_______________

#### Laboratory Information

**Laboratory confirmed:**
- Yes
- No

Test performed:
- acid fast stain (microscopy)
- EIA
- DFA

**Lab or hospital name:** ____________________________

Date specimen(s) collected: ____/____/______

Specimen source:
- Stool
- Other: __________

**Physician Name:** ________________________________

MD Phone: (____)_______________

**Clinic Name:** ____________________________

City/State: ____________________________

#### Clinical Description (Yes=Y; No=N; Unknown=U)

Did the patient have symptoms?:
- Y
- N
- U

If yes, onset date ____/____/______ Time: _____ AM / PM

Did the patient have:
- Diarrhea
- *Abd. cramps
- Greasy stools
- Intermittent diarrhea
- *Bloating
- Fever (max temp_____
- Other: __________

** Please enter symptom data into CEDRS extended record. Asymptomatic cases are considered ‘suspect cases’ and will be reclassified based on symptom data in CEDRS. If patient reports no symptoms, please complete questions on page 2 about recent immigration/refugee/adoption and STOP disease investigation.**

How many days did the illness last? ___________ days

Did case receive antiparasitic medication for this illness? Y N U

Medication name: __________

Outcome:Survived Died Unk

If died, date of death: ____/____/____

Was patient hospitalized? Yes No Unk

(ER visits only not considered “hospitalized”)

If hospitalized:

**Hospital Name:** ____________________________

Date of Admission: ____/____/______

Date of Discharge: ____/____/______

December 2011

Giardiasis Case Investigation Form, Page 1
**Travel information**

*Did patient immigrate to the US during the past 6 months?*  
Yes  No  Unk  

*If yes:*  
*Is patient a refugee?*  Yes  No  Unk  
*Is patient a recent adoptee?*  Yes  No  Unk  

{If pt has no symptoms, STOP here}

Did patient travel outside the US in the 3-25 days prior to the onset of illness?  
Yes  No  Unk  

*If yes,*  
Country  Date left US  Date returned to US  
(1)  
(2)  
(3)  

Did patient travel within the US in the 3-25 days prior to the onset of illness?  
Yes  No  Unk  

*If yes,*  
where/when: ________________________________

**Water** (ask about 3-25 days before onset)

What was patient’s source of drinking water at home?  
☐ Municipal  Name ___________________  
☐ Private source:  Well water  Surface water  (details: ______________ )  
☐ Bottled water  Name ___________________  
☐ Other  _____________________________

Does patient use a water filter at home?  Y  N  U  What type?  _____________________________

Did patient drink any water from a pond, stream, spring, river or lake?  
Yes  No  Unk  

*If yes,*  
was the water treated or filtered prior to use?  Yes  No  Unk  

*If yes,*  
describe procedure used to treat/filter water: ______________________________

Did the patient swim or wade in any of the following types of recreational water?  
Hot tub/spa, whirlpool, Jacuzzi  Y  N  U  
Lake, pond, river, or stream  Y  N  U  
Recreational water park or any type of fountain  Y  N  U  
Swimming or wading pool  Y  N  U  
Drainage ditch/irrigation canal  Y  N  U  
Other, specify: ________________________________

Did the patient participate in other water activities such as fishing, kayaking, canoeing or other boating?  
Yes  No  Unk

**Pet or animal exposure**

Did the patient visit or live on a farm within 3-25 days prior to illness?  
Yes  No  Unk  

Visit any animal exhibits (petting zoo, county fair, etc)  
Yes  No  Unk  

*If yes to either,*  
did the case have exposure to manure?  
Yes  No  Unk

Have a pet or contact with other people’s pets?  
Yes  No  Unk

*If yes to any of these,*  
indicate the animals with which patient had contact:  
Dog/puppy  Y  N  Other?  specify: ________________________________

Cat/kitten  Y  N

Were any of these animals recently acquired or recently ill?  
Y  N

*If Yes,*  
provide details: ________________________________
Patient Name: _______________________   CEDRS # ___________

Restaurant history/Group activities
Any restaurants, group gatherings, picnics, or sporting events during the 3-25 days before illness?   Yes   No   Unk
If yes,    Name  Address  Date of Exposure  Foods Eaten
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Did others accompanying the case become ill with diarrhea, fever, or abdominal pain?   Yes   No   Unk
(If others became ill after a common exposure, this may be an outbreak.  Call regional epidemiologist or CDPHE for assistance.)

School/Work
Occupation: _______________________  Student?  Yes  No
Place of Employment: ________________  If yes, Name of School: ________________

Does the case…
Attend, work or volunteer at a child care center / preschool?  Yes  No  Unk
Have a child(ren) in a child care center?  Yes  No  Unk
Attend, work or volunteer at a residential facility? (e.g. nsg home)  Yes  No  Unk
If yes to any of the above,
Name and location of facility ____________________________________________________________
Are other children/staff ill?  Yes  No  Unk
Provide direct patient care as a health care worker?  Yes  No  Unk
If yes, name and location of facility ____________________________________________________________
Work as a food handler?  Yes  No  Unk
If yes, name and location of facility ____________________________________________________________

Since the case became ill, did case prepare food for any public or private gatherings?  Yes  No  Unk
If yes, provide details:_________________________________________________________________

Contact management
Complete the table below for all household members and other close contacts. If any of these persons has been ill with similar symptoms, please indicate the date of onset and symptoms.

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Occupation/Child Care</th>
<th>Similar illness</th>
<th>Onset m d y</th>
<th>Comments</th>
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Epi-links
Is any person listed above already a confirmed or suspected case in CEDRS?  Yes  No  Unk
If yes, CEDRS#__________
Is this patient part of a known/suspected outbreak?  Yes  No  Unk
If yes, specify:__________

If case or household contact is high risk (food handler, health care worker, child care) refer to CD manual for restrictions/follow up. Obtain details of site, job description, dates worked/attended during communicable period, supervisor name, etc.
Patient Name: _______________________ CEDRS # ___________

Notes:

Summary of follow up

☐ Hygiene education provided  ☐ Child care center inspected
☐ Work or childcare restriction for case  ☐ Testing of home or other water source
☐ Follow up of other household members  ☐ ____________________

Questions about filling out this form?
Contact the Communicable Disease Epidemiology Program at 303-692-2700, 800-866-2759
After finishing case interview, update the CEDRS record. Do NOT send this form to CDPHE unless it is requested (e.g. as part of a suspected outbreak).