

**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.

**CRYPTOSPORIDIOSIS**

**Confidential Communicable Disease Report—Part 2  
NC DISEASE CODE: 56**

**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: \_\_\_\_\_

**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): / /

**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

**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

**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: \_\_\_\_\_

**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  U  
 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:**

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Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
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**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  Thyme  
 Parsley  Cilantro  
 Oregano  Rosemary  
 Cumin  
 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: \_\_\_\_\_

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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* spp.)

## 2012 Case Definition

CSTE Position Statement Number: 11-ID-14

### Clinical Description

A gastrointestinal illness characterized by diarrhea and one or more of the following: diarrhea duration of 72 hours or more, abdominal cramping, vomiting, or anorexia.

### Laboratory Criteria for Diagnosis

#### Confirmed

- Evidence of *Cryptosporidium* organisms or DNA in stool, intestinal fluid, tissue samples, biopsy specimens, or other biological sample by certain laboratory methods with a high positive predictive value (PPV), e.g.,
- Direct fluorescent antibody [DFA] test,
- Polymerase chain reaction [PCR],
- Enzyme immunoassay [EIA], or
- Light microscopy of stained specimen.

#### Probable

The detection of *Cryptosporidium* antigen by a screening test method, such as immunochromatographic card/rapid card test; or a laboratory test of unknown method.

### Case Classification

#### Probable

- A case with supportive laboratory test results for *Cryptosporidia* spp. infection using a method listed in the probable laboratory criteria. When the diagnostic test method on a laboratory test result for cryptosporidiosis cannot be determined, the case can only be classified as probable, OR
- A case that meets the clinical criteria and is epidemiologically linked to a confirmed case.

#### Confirmed

A case that is diagnosed with *Cryptosporidium* spp. infection based on laboratory testing using a method listed in the confirmed criteria.

#### Comment

Persons who have a diarrheal illness and are epidemiologically linked to a probable case because that individual was only diagnosed with cryptosporidiosis by an immunocard/rapid test/ or unknown test method cannot be classified as probable cases. These epi-links can be considered suspect cases only.