



Send completed forms
DPHHS CD Epi Program
Fax: 800-616-7460

Case ID _____
 Reported to DOH Date ___/___/___
 LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Epi Link: _____

Outbreak-related
 LHM Cluster #

 DPHHS Outbreak #

Giardiasis

County _____

REPORT SOURCE

Initial report date ___/___/___
 Reporter (check all that apply)
 Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No Don't know

Investigation start date: ___/___/___

Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____
 Address _____ Homeless
 City/State/Zip _____
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name _____ Zip _____
 code (school or occupation): _____ Phone _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____
 Gender F M Other Unk
 Ethnicity Hispanic or Latino
 Not Hispanic or Latino
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other

CLINICAL INFORMATION

Onset date: ___/___/___ Derived Diagnosis date: ___/___/___ Illness duration: _____ days

SIGNS AND SYMPTOMS

Y N ? NA
 Diarrhea Maximum # of stools in 24 hours: _____
 Pale, greasy or odorous stool
 Abdominal cramps or pain
 Weight loss with illness
 Bloating or gas

PREDISPOSING CONDITIONS

Y N ? NA
 Immunosuppressive therapy or disease

HOSPITALIZATION

Y N ? NA
 Hospitalized for this illness

Hospital name _____
 Admit date ___/___/___ Discharge date ___/___/___

Y N ? NA
 Died from illness Death date ___/___/___
 Autopsy Place of death _____

LABORATORY

Collection date ___/___/___
 Source _____

P N I O NT
 G. lamblia antigen by immunodiagnostic test such as EIA (stool)
 G. lamblia cysts (stool)
 G. lamblia trophozoites (stool, duodenal fluid, small-bowel biopsy)

P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

NOTES

INFECTION TIMELINE

Enter onset date and time (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods



EXPOSURE (Refer to dates above)

- Patient could not be interviewed
- No risk factors or exposures could be identified

LEAD-IN QUESTIONS

- Y N ? NA
- Did you travel?
Out of: County State Country
Dates/Locations: _____

- Does case know anyone else with similar symptoms?
- Contact with lab confirmed case
 Casual Household Sexual
 Needle use Other: _____
- Epidemiologic link to a confirmed human case**

EXPOSURE QUESTIONS

- Y N ? NA
- Contact with diapered or incontinent child or adult
 - Group meal (e.g. potluck, reception)
 - Food from restaurants
Restaurant name/location: _____

- Y N ? NA
- Source of drinking water known
 Individual well Shared well
 Public water system Bottled water
 Other: _____
 - Drank untreated/unchlorinated water (e.g. surface, well)
 - Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)
 - Case or household member lives or works on farm or dairy
 - Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse)
Specify animal: _____
 - Exposure to pets
Was the pet sick Y N ? NA
 - Zoo, farm, fair or pet shop visit
 - Any contact with animals at home or elsewhere
Type? _____
 - Foreign arrival (e.g. immigrant, refugee, adoptee, visitor)
Specify country: _____
 - Any type of sexual contact with others during exposure period:
female sexual partners: _____
male sexual partners: _____

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? In MT (County: _____) US but not MT Not in US Unk

PATIENT PROPHYLAXIS / TREATMENT

PUBLIC HEALTH ISSUES

- Y N ? NA
- Employed as food worker
 - Non-occupational food handling (e.g. potlucks, receptions) during contagious period
 - Employed as health care worker
 - Employed in child care or preschool
 - Attends child care or preschool
 - Household member or close contact in sensitive occupation or setting (HCW, child care, food)

PUBLIC HEALTH ACTIONS

- Consider excluding case in sensitive occupation until diarrhea ceases
- Consider excluding symptomatic contacts in sensitive occupations or situations until diarrhea ceases
- Work or child care restriction
- Test symptomatic contacts
- Hygiene education provided
- Restaurant inspection
- Child care inspection
- Other, specify: _____

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ___/___/___
Local health jurisdiction _____ Record complete date ___/___/___