

NBS Patient ID \_\_\_\_\_ NBS CAS ID \_\_\_\_\_

International Travel : Yes \_\_\_\_\_ No \_\_\_\_\_



06/06/2016 V1 **Texas DSHS Cyclospora Cover Sheet**

\*Please complete this cover sheet for all cases of *Cyclospora* in addition to CDC's **Cyclospora National Hypothesis Generating Questionnaire** (CNHGQ). Please submit completed forms to DSHS Central Office by fax (512-776-7616) or email (FOODBORNETEXAS@dshs.state.tx.us)

**CASE STATUS:**  CONFIRMED  PROBABLE (EPI-LINKED NBS or CAS ID: \_\_\_\_\_)  NOT A CASE

<p><b>Patient's name:</b> _____  <div style="display: flex; justify-content: space-between; width: 100%;"> <span><b>Last</b></span> <span><b>First</b></span> </div> <b>Address:</b> _____  <b>City:</b> _____ <b>County:</b> _____ <b>Zip:</b> _____  <b>Region:</b> _____ <b>Phone:</b> ( ) _____  <b>DOB:</b> ___/___/___ <b>Age:</b> _____ <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown  <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native            American/Alaskan <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____ <b>Hispanic:</b> <input type="checkbox"/> Yes  <input type="checkbox"/> No <input type="checkbox"/> Unknown  <b>Parent/Guardian:</b> _____</p>	<p><b>Date reported to Public Health:</b> ___/___/___  <b>Reported by:</b> _____  <b>Phone:</b> ( ) _____            .....  <b>Investigated by:</b> _____  <b>Agency:</b> _____  <b>Phone:</b> ( ) _____  <b>Email:</b> _____  <b>Date Investigation Initiated:</b> ___/___/___  <b>Date Completed:</b> ___/___/___</p>
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**Onset date:** \_\_\_/\_\_\_/\_\_\_ **Hospitalized?**  Yes  No  Unknown **Hospitalized at:** \_\_\_\_\_  
**Admitted:** \_\_\_/\_\_\_/\_\_\_ **Discharged:** \_\_\_/\_\_\_/\_\_\_ **Duration of Stay** \_\_\_\_\_ days

**Specimen collection date:** \_\_\_/\_\_\_/\_\_\_ **Laboratory Name:** \_\_\_\_\_  
 If known, specify testing method: \_\_\_\_\_  
 (e.g., wet mount/concentrate stain, modified acid-fast, PCR, etc.)

**Has the case-patient been treated** (or is he/she being treated) for cyclosporiasis?  Yes  No  Unknown  
*If yes, what medication(s)?*  Trimethoprim/sulfamethoxazole (e.g., Bactrim, Septra, Cotrim)  
 Other (*specify*): \_\_\_\_\_  Unknown

**Is case-patient allergic to (or intolerant of) sulfa drugs?**  Yes  No  Unknown

**Tracking of CNHGQ Interview Attempts:**

Attempts:	Day	Date	Time	Interviewer	Comments
Example	M	7/26/11	3:30pm	JB	Requested to call back on Tuesday at 7:00pm
1 <sup>st</sup>					
2 <sup>nd</sup>					
3 <sup>rd</sup>					
4 <sup>th</sup>					
Completed					
Faxed					Fax to DSHS Central Office: <b>512-776-7616</b>

**For DSHS Central Office only:**  NBS approved \_\_\_/\_\_\_/\_\_\_  Case track information entered on line list \_\_\_/\_\_\_/\_\_\_  
**Date CNHGQ received :** \_\_\_/\_\_\_/\_\_\_  Completed  Partial  LTF  
 CNHGQ link requested: \_\_\_/\_\_\_/\_\_\_  CNHGQ data entered: \_\_\_/\_\_\_/\_\_\_