HEALTH DEPARTMENT USE ONLY:
Medical Care Facility _______________ Visit Date(s) ____________
Treating Physician _______________ Outbreak #___________
Interviewer Initials __________ Interview Date ___________

ODH USE ONLY Report Number __________
Report Date ___________ Case Classification Susp. Prob. Conf. Not a Case
Review Team Date ___________
Notification Date ___________
LHD Notified of Case Classification By _________________________________

HARMFUL ALGAL BLOOM-RELATED HUMAN ILLNESS REPORT— DRINKING WATER EXPOSURE

Identifying information for ill individuals:

Name ____
Phone ____
Address ____
County ____
ZIP code ____
Name of interviewee ______________________ **Relationship** ________________

Source(s) of report:

❒ Resident
❒ Healthcare Provider
❒ State Agency
❒ County Agency
❒ Poison Control Center
❒ Medical record
❒ Other

Address ___________________________
____
Phone number _____________________
____

Demographics

Date of birth ________ *or* **Age**_____ (years or months) **Sex** ❒Male ❒Female **Height** ______ inches **Weight**______lbs
Race ❒American Indian ❒Asian/Pacific Islander ❒Black ❒White ❒Unknown ❒Other **Hispanic** ❒Yes ❒No

Exposure Information

Between ________________ (dates)**, what was your primary source of drinking water?**
❒ Well water ❒ Municipal water from tap (specify Water Utility if known) __________ ❒Commercially bottled water ❒ Other (specify) _________
If you drank municipal water from tap, where did you drink it? (Check all that apply)
❒ Home ❒ Work ❒ School ❒ Daycare ❒ Other (specify) __________ Address ____

Between __________________, did you drink any tap water (even if it was only a mouthful)?
❒Yes ❒No
If yes, how much did you drink?
❒ A mouthful ❒ A cup (8 ounces) ❒ More than a cup _______ (# cups)

Between __________________, did you use tap water to make coffee or tea?
❒Yes ❒No
If yes, how much did you drink?
❒ A mouthful ❒ A cup (8 ounces) ❒ More than a cup _______ (# cups)

Between __________________, did you use tap water to make other beverages (e.g. fruit juice, powdered drink mix)?
❒Yes ❒No
If yes, how much did you drink?
❒ A mouthful ❒ A cup (8 ounces) ❒ More than a cup _______ (# cups)

Between __________________, did you use ice made from tap water in any additional beverages?
❒Yes ❒No

Between __________________, did you use tap water to make baby formula?
❒Yes ❒No
If yes, how many ounces did the child drink? _______ ounces

Between __________________, did you use tap water in cooking or preparing food? ((e.g. soup, pasta, rice, cereal, potatoes, vegetables)
❒Yes ❒No

Between __________________, did you use tap water to brush your teeth or clean dentures?
❒Yes ❒No
If yes, did you swallow any tap water?
❒Yes ❒No

Between __________, did you use tap water in a nasal/sinus irrigator or Neti pot?
❒Yes ❒No

Between __________________, did you use tap water to shower?
❒Yes ❒No
If yes, did you swallow any water?
❒Yes ❒No
How long was your shower? _______ minutes

Between __________________, did you use tap water to take a bath?
❒Yes ❒No
If yes, did you swallow any water?
❒Yes ❒No
How long was your bath? _______ minutes

Between __________________, did you use tap water to wash your hands/face?
❒Yes ❒No
If yes, how many times did you wash your hands/face? _______

Between __________________, did you use tap water to wash fruits or vegetables?
❒Yes ❒No
If yes, did you wear gloves?
❒Yes ❒No

Between __________________, did you use tap water to hand wash dishes?
❒Yes ❒No
If yes, did you wear gloves?
❒Yes ❒No

Between __________________, did you use tap water to water a garden, lawn, or other plants?
❒Yes ❒No

Between __________________, did you use tap water with a cool mist vaporizer/humidifier, nebulizer or CPAP?
❒Yes ❒No

Between __________________, did you use tap water for any outdoor recreational activities (e.g.kiddie pool, slip-n-slide, sprinkler)?
❒Yes ❒No
If yes, did you swallow any water?
❒Yes ❒No

Between __________________, did you have any other exposure to tap water?
❒Yes ❒No
If yes, please explain: ____
____
____
____

Signs and Symptoms *(onset is the date the symptom first appeared, duration length of time in hours)*

Symptomatic? ❒ Yes ❒ No ❒ Unknown Date of Onset ______________________________

What symptom(s) did you first experience? ____

Chief symptoms

General

❒Fatigue	Onset _______	Duration _______	❒Loss of appetite	Onset _______	Duration _______
❒Fever	Onset _______	Duration _______	❒Malaise	Onset _______	Duration _______

HEENT

❒Earache	Onset _______	Duration _______	❒Nasal congestion	Onset _______	Duration _______
❒Headache	Onset _______	Duration _______	❒Sore throat	Onset _______	Duration _______
❒Conjunctivitis	Onset _______	Duration _______	❒Other_______	Onset _______	Duration _______

Respiratory

❒Cough	Onset _______	Duration _______	❒Chest tightness	Onset _______	Duration _______
❒Short of breath	Onset _______	Duration _______	❒Other_______	Onset _______	Duration _______
❒Wheezing	Onset _______	Duration _______			

Cardiovascular

❒Chest pain	Onset _______	Duration _______	❒Cyanosis	Onset _______	Duration _______
❒Irregular beat	Onset _______	Duration _______	(check all that apply:	__arms __legs__ mouth)	
❒Other _______	Onset _______	Duration _______	❒Pale (arms, legs)	Onset _______	Duration _______

Gastrointestinal

❒Nausea	Onset _______	Duration _______	❒Vomiting	Onset _______	Duration _______
❒Diarrhea	Onset _______	Duration _______	❒Pain (up R quadrant)	Onset _______	Duration _______
❒Other _______	Onset _______	Duration _______	❒Bad taste in mouth	Onset _______	Duration _______

Genitourinary

❒Dark urine	Onset _______	Duration _______	❒Other_______	Onset _______	Duration _______
❒Blood in urine	Onset _______	Duration _______			

Musculoskeletal

❒Muscle pain	Onset _______	Duration _______	❒Difficulty walking	Onset _______	Duration _______
❒Joint pain	Onset _______	Duration _______	❒Other_______	Onset _______	Duration _______

Neurologic

❒Confusion	Onset _______	Duration _______	❒Numbness	Onset _______	Duration _______
❒Memory loss	Onset _______	Duration _______	❒Weakness	Onset _______	Duration _______
❒Seizure	Onset _______	Duration _______	❒Paralysis	Onset _______	Duration _______
❒Coma	Onset _______	Duration _______	❒Vertigo	Onset _______	Duration _______
❒Other_______	Onset _______	Duration _______	❒Tingling/burning	Onset _______	Duration _______
			❒Vision disturbance	Onset _______	Duration _______

Mental health

❒Anxiety/nervousness	Onset _______	Duration _______	❒Other_______	Onset _______	Duration _______
❒Depression	Onset _______	Duration _______			

Dermatologic

❒Itching	Onset _______	Duration _______	❒Rash	Onset _______	Duration _______
❒Blisters	Onset _______	Duration _______	❒Jaundice	Onset _______	Duration _______
❒Other_______	Onset _______	Duration _______			

If rash reported, identify the location of the rash (check all that apply):

❒Left hand/arm | Right hand/arm ❒Left foot/leg ❒Right foot/leg ❒Face ❒Neck ❒Chest ❒Back

❒Under Swimsuit/diaper ❒Other ___________________________________

Describe the appearance of the rash

____

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Medical Information

Do you have any pre-existing medical condition(s)?

❒Yes ❒No ❒Unknown

If yes, check all that apply.

❒Asthma
❒Chronic respiratory disease
❒Chronic skin disease
❒Diabetes mellitus
❒Heart disease
❒Immunodeficiency disorder
❒Intestinal disorder (Crohn's disease, Celiac disease)
❒Liver disease (hepatitis, cirrhosis, fatty liver, jaundice)
❒Malignancy
❒Neurologic disorders
❒Psychological disorder
❒Renal disease

If yes, do you receive dialysis? ❒Yes ❒No

❒Transplant recipient

Other____

(If female is of reproductive age) Are you currently pregnant or breastfeeding?

❒Yes ❒No ❒Unknown

Did you use a dietary supplement made from blue-green algae or Super Blue-Green? ❒Yes ❒No ❒Unknown

Do you take herbal supplements or drink herbal teas routinely?

❒Yes ❒No ❒Unknown

If yes, describe

____

Did you use any prescribed medication, OTC, or supplements in the month before onset of symptoms?

❒Yes ❒No ❒Don't know

If yes, list ALL ____

____

____

Have you had a cold or flu in the past 2 weeks?

❒Yes ❒No ❒Don't know

How often do you drink alcohol containing beverage(s)?

❒Never ❒< 1/wk ❒>1/wk ❒Daily

How many drinks containing alcohol do you drink in a typical day?

❒1-2 ❒3-4 ❒>5

Did you drink alcohol within 24 hours prior to symptom onset?

❒Yes ❒No ❒Don't Know

Do you smoke? ❒Yes ❒No ❒Don't Know

If yes, how many packs a day? _______

Is there anything else you would like to add?

____

____

Assessment

Medical Care sought ❒Yes ❒No ❒Unknown

If yes, type of facility ❒Clinic ❒ER ❒Urgent care

Visit date(s) ____

Provider ____

Location ____

Phone number ____

Were lab tests conducted? ❒Yes ❒No ❒Unknown

If yes, type and results (attach documentation)

❒Blood tests ____
❒Cultures____
❒Fecal smears____
❒Histopathology____
❒Skin biopsies____
❒Toxins____
❒Urinalysis____
❒X-ray____

Current disposition?

❒Released ❒Still hospitalized ❒Unknown ❒Deceased

Notes: ____

If deceased, was an autopsy performed?

❒Yes ❒No ❒Pending ❒Unknown

[If yes, attach copy of preliminary and/or final report]

Photos ❒Yes ❒No (If yes, attach a signed release)

Other exposed people ____

____

Description ____

Report by (*name*) ____

FOR HEALTH DEPARTMENT USE ONLY:

Illness report status ❒Complete
❒Follow-up required (*describe in follow-up section)*

Follow-up needed ____

____

ODH-Assigned Case classification **based on case definitions, page 4*

❒Suspect HAB-related case*
❒Probable HAB-related case*
❒Confirmed HAB-related case*
❒Not a HAB-related case

If not HAB-related, what diagnosis ______________________________

Notes ____

____

Source of final diagnosis ______________________________

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Case definition summary for selected toxins:

Definition	Criteria							
Human HAB-associated Case	**Exposure**[1]	**Signs/ symptoms**[2]	**Public health assessment**[3]	**Professional medical diagnosis**[4]	**Other causes of illness ruled out**	**Observational or environmental data**[5]	**Laboratory-based HAB data**[6]	**Clinical data**[7]
1. Suspect	Required	Required	Required					
2. Probable	Required	Required	Required			Required to have 1		
3. Probable	Required	Required	Required	Required	+/-	+/-	+/-	
4. Confirmed	Required	Required	Required	Required to have 1		+/-	+/-	Required
5. Confirmed	Required	Required	Required	Required	Required		Required	

FOOTNOTES FOR CASE DEFINITIONS:

[1] Exposure (i.e. physical contact, inhalation, ingestion) to water, algae, or seafood, dietary supplements

[2] Self-reported signs/symptoms after exposure

[3] Public health assessment is defined as the action of compiling all data available and deciding that the illness in question is likely HAB-related

[4] Professional medical diagnosis being provided by a medical practitioner (e.g., doctor, nurse, physician assistant) based on his or her medical assessment of the patient's symptoms, medical history, exposure, etc.

[5] Observational (e.g., scum, algae, water color change, sheen, photographic evidence, satellite data) or environmental (e.g., pH, chlorophyll, nutrient levels) data from a water body to supporting the presence of an algal bloom

[6] Laboratory detection of cyanobacteria or other potentially toxin-producing algae, (e.g., microscopic confirmation or DNA analyses) or algal/cyanobacterial toxins (e.g., bioassay, HPLC) in a water body, finished drinking water supply, seafood or dietary supplements

[7] Laboratory documentation of cyanobacteria, other potentially toxin-producing algae, or algal/cyanobacterial toxins in a clinical specimen. *Currently no CLIA-certified assay is available.*

+/-: indicates that this criteria is optional and while it strengthens the case, it does not change case classification (e.g., suspect to probable, probable to confirmed).

Healthcare Providers:
Please complete form, and telephone the Local Health Department of the residence of the ill individual for form submission instructions. A list of health departments may be found at: http://www.odh.ohio.gov/~/media/ODH/ASSETS/Files/lhd/OHIO-LHDcontact.ashx

If you are unable to identify the jurisdiction of residence, please telephone to your Local Health Department.

Local Health Departments:
Please fax forms to:
(614) 466-4556 (secure)
Harmful Algal Blooms (HAB)
Bureau of Environmental Health and Radiation Protection (BEHRP)
Ohio Department of Health (ODH)

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