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—RECREATIONAL 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

Date(s) of exposure _____
Time(s) of exposure _____
Duration(s) of exposure _____ hours/minutes
Activity at time of exposure
❒ Occupational _____
❒ Recreational
Circle: Swimming, wading, boating, fishing, tubing/skiing, personal watercraft
❒ Don't know
❒ Other _____

Location
❒ At home
❒ Water body
Name _____
❒ Beach/shoreline
Location _____
❒ Other_____

Route
❒ Inhalation
❒ Dermal contact
❒ Ingestion
❒ Don't know
❒ Other_____

Source
❒ Food
❒ Fresh water
❒ Dietary supplement
product name:
_____and
manufacturer:_____
❒Other_____

Areas in contact with water
❒ Head or Face
❒ Arms or Hands
❒ Legs or Feet
❒ Neck
❒ Trunk
❒ Other_____
❒ Don't know

Environmental conditions

Sick or dead animals
❒ No
❒ Dead fish Count _____
❒ Other dead animals
Count _____ species _____
❒ Other sick animals
Count _____ species _____
❒ Don't know

Unusual odors
❒ No
❒ Yes
If yes, describe _____
❒ Don't know

Water body conditions
❒ Moving
❒ Stagnant
❒ Don't know
Color _____
Clarity _____

Scum or foam present
❒ No
❒ Yes
❒ Don't know

Was the exposure associated with a verified bloom?
❒Yes ❒No ❒Unknown

If source was food/dietary supplement

Type of food
❒ Shellfish
❒ Finfish
❒ Lobster/crab/shrimp
❒ Other_____

Preparation
❒ Cooked
❒ Raw
❒ Unknown

Store bought
❒ Yes, name_____
City/state _____
❒ No
❒ Unknown

Restaurant
❒ Yes, name_____
City/state _____
❒ No
❒ Unknown

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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)

Ohio Department of Health

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