

CHOLERA CASE INVESTIGATION FORM

Please complete and submit with Notification Form (GW17/5) and laboratory results to
Provincial Communicable Diseases Control Officer and NICD (outbreak@nicd.ac.za)

SECTION A: INTERVIEW DETAILS

Interviewer name		Date of interview	DD / MM /20 YY
District			
Telephonic reporting by			
Presenting Health Care Facility			
GPS co-ordinates of place of interview	<input type="checkbox"/> Unknown		

SECTION B: DEMOGRAPHIC DATA

Patient name		Date of birth	DD / MM / YYYY
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Contact number	
Age (in years)		Additional contact number	
Home address: Street		Do you reside at the address given?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suburb		If no, where do you normally live?	
Town			
Province			
Postal code			
GPS co-ordinates of home (address provided directly above)	<input type="checkbox"/> Unknown		
GPS co-ordinates of where you normally live (if not the same as home)	<input type="checkbox"/> Unknown		
If an adult - do you work/study	<input type="checkbox"/> Yes <input type="checkbox"/> No	What is your occupation?	
Details of workplace / place of study	Name		
	Physical address		
If a child, does the child attend day care/crèche/school?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, give day care/crèche/school name:			
Telephone number:			
Address:			
Who was interviewed?	<input type="checkbox"/> The Case <input type="checkbox"/> Other		
If "other", specify	Name		
	Relation to case		
	Contact Tel. No.		



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SECTION C: DETAILS ABOUT ILLNESS

Date of onset of diarrhoea	DD / MM / YYYY		
Last day on which diarrhoea occurred	DD / MM / YYYY	Is diarrhoea still present?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which of the following symptoms is/ were present during the illness?	<input type="checkbox"/> Watery diarrhoea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal cramps <input type="checkbox"/> Other – specify other _____		
Were stool specimens collected?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes: Laboratory name			
If yes: Specimen reference no.			
Were you admitted to hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes: Name of Hospital			
If yes: Date admitted:	DD / MM / YYYY	Number of days in hospital?	
Nature of diagnosis	<input type="checkbox"/> Clinical only <input type="checkbox"/> Laboratory confirmed (<i>V.cholerae</i> isolated from stool/rectal swab)		
Has the case been notified?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, case notification number:	

SECTION D: EXPOSURE HISTORY

Did you travel anywhere in the last 10 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
If Yes: Travel Destination	Departure date	Return date	
	DD / MM / YYYY	DD / MM / YYYY	
	DD / MM / YYYY	DD / MM / YYYY	
Did you have contact with anyone who had travelled outside your province of residence in the 10 days before your diarrhoea started?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
If Yes: Who? Where did they travel to? (Destination)	Departure date	Return date	Date of contact
	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Did you have any visitors from outside your province of residence in the 10 days before your diarrhoea started?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
If Yes: Who? Where did they come from?	Departure date	Return date	Date of contact
	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
	DD / MM / YYYY	DD / MM / YYYY	DD / MM / YYYY
Were you in contact with anyone who had diarrhoea in the 10 days before your diarrhoea started?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
<u>If yes, specify</u>	Name	Relation	Date(s) of contact
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY
Did you attend any gatherings or events (wedding receptions, festivals, funerals, church gatherings, choir gathers, baptisms, etc.) in the 10 days before your diarrhoea started?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		



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If yes, specify	Event	Location/venue	Date
			DD / MM / YYYY
			DD / MM / YYYY
			DD / MM / YYYY

AT HOME, indicate which water is used for which use (tick all applicable)

Type of water	Drinking	Preparing food	Bathing	Brushing teeth
Municipal tap water indoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Municipal tap water outdoors but on your property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Municipal common source water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private well/borehole water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Untreated surface water (river, pond, dam)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AT WORK / SCHOOL / DAY-CARE, indicate which water is used for which use (tick all applicable)

Type of water	Drinking	Preparing food	Bathing	Brushing teeth
Municipal tap water indoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Municipal tap water outdoors but on your property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Municipal common source water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private well/borehole water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Untreated surface water (river, pond, dam)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In what type of containers do you store your water (not refrigerated water)? (Please mark all applicable)	<input type="checkbox"/> Plastic containers without lids <input type="checkbox"/> Plastic containers with lids <input type="checkbox"/> Metal containers without lids <input type="checkbox"/> Metal containers with lids
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What do you use to scoop water from the container?

Where did you shop for fresh fruit or vegetables in the last 10 days? (Please complete the table below)

Store name / Vendor	Location

Where did you buy your milk in the last 10 days? (Please complete the table below)

Store name / Vendor	Location

Did you eat or drink any unpasteurised dairy/milk products in the 10 days prior to your illness onset? Yes No Don't know

If yes, then where?



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In the 10 days before your illness onset, did you eat food/beverages at or from any of the following types of places outside of your home? Tick which of them apply and provide details

Type of establishment	Name and location	Date	Foods/beverages consumed
<input type="checkbox"/> Restaurant		DD / MM / YYYY	
<input type="checkbox"/> Fast food establishments		DD / MM / YYYY	
<input type="checkbox"/> Work canteen		DD / MM / YYYY	
<input type="checkbox"/> Deli		DD / MM / YYYY	
<input type="checkbox"/> Supermarket ready-to-eat food		DD / MM / YYYY	
<input type="checkbox"/> Street vendor foods		DD / MM / YYYY	
<input type="checkbox"/> Snack-bar or tuck shop		DD / MM / YYYY	
<input type="checkbox"/> Petrol station		DD / MM / YYYY	
<input type="checkbox"/> Another household		DD / MM / YYYY	

Who prepares food in your household?

What water do you use to wash fruit and vegetables?

AT HOME **AT WORK**

a) Which forms of toilet do you make use of?

<input type="checkbox"/> Indoor flushing toilet <input type="checkbox"/> Flushing toilet on stand but outside house <input type="checkbox"/> Pit Latrine <input type="checkbox"/> Other _____	<input type="checkbox"/> Indoor flushing toilet <input type="checkbox"/> Flushing toilet on stand but outside house <input type="checkbox"/> Pit Latrine <input type="checkbox"/> Other _____
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b) Which of the following are available at the toilet?

<input type="checkbox"/> Tap with running water <input type="checkbox"/> Soap	<input type="checkbox"/> Tap with running water <input type="checkbox"/> Soap
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Have you or any member of your household used the stream for any activities in the 10 days prior to your diarrhoea started?

Yes No Don't know

If yes, what activities?

SECTION E: GENERAL EHP ASSESSMENT

General hygiene conditions in the home? (Remember to check where and how food and water is stored and for how long?)



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Food and water storage assessment?

Overcrowded conditions?

Refuse removal?

Pest problems at home?

Any other comments:

YOU HAVE REACHED THE END. THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.