State of California—Health and Human Services Agency

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

Local ID Number ____________________

(*Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)*

Report Status (check one)
☐ Preliminary ☐ Final

CHOLERA AND OTHER *VIBRIO* ILLNESS CASE REPORT

Check one: ☐ Cholera
☐ Non-cholera *Vibrio* illness

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	☐ Years ☐ Months ☐ Days

Address Number & Street - Residence	*Apartment / Unit Number*

City / Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone / Pager*	*Work / School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work / School Location	*Work / School Contact*

Gender
☐ Male ☐ Female ☐ Other: ____________________

Pregnant? ☐ Yes ☐ No ☐ Unk	*If Yes, Est. Delivery Date (mm/dd/yyyy)*
Medical Record Number	*Patient's Parent / Guardian Name*
Occupation Setting (see list on page 10)	*Other (Describe / Specify)*
Occupation (see list on page 10)	*Other (Describe / Specify)*

Primary Language
☐ English
☐ Spanish
☐ Other:____________________

Ethnicity (check one)
☐ Hispanic / Latino
☐ Non-Hispanic / Non-Latino
☐ Unk

*Race**
(check all that apply, race descriptions on page 10)
☐ African-American / Black
☐ American Indian or Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Japanese
- ☐ Cambodian ☐ Korean
- ☐ Chinese ☐ Laotian
- ☐ Filipino ☐ Thai
- ☐ Hmong ☐ Vietnamese
- ☐ Other:____________________

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian
- ☐ Other:____________________

☐ White
☐ Other:____________________
☐ Unk

*Comment: self-identity or self-reporting

The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

First three letters of patient's last name: | | | |

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unk	Onset Date (mm/dd/yyyy)	Onset Time (hh:mm)	Specify AM/PM ☐ AM ☐ PM	Duration of Illness (days)

Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Fever (>100.4°F or 38°C)				*Highest Temperature (specify °F / °C)*
Vomiting				
Diarrhea				*Max. Number of Stools in 24-hr Period*
Bloody diarrhea				
Abdominal cramps				
Muscle pain				
Cellulitis				*Location*
Bullae				*Location*
Septic shock				
Ear pain or discharge				
Sequelae (e.g., amputation, skin graft)				*Type*
Other (specify)				

PAST MEDICAL HISTORY

History	Yes	No	Unk	If Yes, Specify as Noted
Ever received a cholera vaccine				*Most Recent Vaccination Date (mm/dd/yyyy)*
Underlying Medical Conditions				
Diabetes				*On insulin?* ☐ Yes ☐ No ☐ Unk
Peptic ulcer				
Gastric surgery				*Type*
Heart disease				*Heart failure?* ☐ Yes ☐ No ☐ Unk
Liver disease				*Type*
Cancer (Malignancy)				*Type*
Kidney disease				*Type*
Hematologic disease				*Type*
Immunodeficiency disorder				*Type (Please do NOT disclose or specify HIV/AIDS information on this form.)*
Drink alcohol				*How many servings of alcohol in a typical week?*
Other (specify)				

First three letters of patient's last name: | | | |

RECENT TREATMENT HISTORY (in the 30 days PRIOR to the illness onset date)					
Treatment	**Yes**	**No**	**Unk**	**If Yes, Specify as Noted**	
Antibiotics				*Treatment Name* ☐ Amoxicillin ☐ Azithromycin ☐ Cephalexin ☐ Ciprofloxacin ☐ Other (specify):_____________	
Chemotherapy					
Radiotherapy					
Systemic steroids					
Immunosuppressants					
Antacids (e.g., Mylanta, Tums, Rolaids)				*Treatment Name*	*Frequency*
H2 blocker or other ulcer medications (e.g., Pepcid, Prilosec, Tagamet)				*Treatment Name*	*Frequency*

HOSPITALIZATION		
Did patient visit emergency room for illness? ☐ Yes ☐ No ☐ Unk	*Was patient hospitalized?* ☐ Yes ☐ No ☐ Unk	*If Yes, how many total hospital nights?*
If there were any ER or hospital stays related to this illness, specify details below.		

HOSPITALIZATION – DETAILS					
Hospital Name 1	*Street Address*			*Admit Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*
Hospital Name 2	*Street Address*			*Admit Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*

TREATMENT / MANAGEMENT	
Received treatment? ☐ Yes ☐ No ☐ Unk	*If Yes, specify the treatments below.*

TREATMENT / MANAGEMENT – DETAILS			
Treatment Type 1 ☐ Antibiotic ☐ Other	*Treatment Name* ☐ Azithromycin ☐ Ciprofloxacin ☐ Doxycycline ☐ Levoquin ☐ Other (specify): _____________	*Date Started (mm/dd/yyyy)*	*Date Ended (mm/dd/yyyy)*
Treatment Type 2 ☐ Antibiotic ☐ Other	*Treatment Name* ☐ Azithromycin ☐ Ciprofloxacin ☐ Doxycycline ☐ Levoquin ☐ Other (specify): _____________	*Date Started (mm/dd/yyyy)*	*Date Ended (mm/dd/yyyy)*

OUTCOME		
Outcome? ☐ Survived ☐ Died ☐ Unk	*If Survived,* Survived as of_________________________(mm/dd/yyyy)	*Date of Death (mm/dd/yyyy)*

First three letters of patient's last name: | | | |

LABORATORY INFORMATION

LABORATORY RESULTS SUMMARY

Collection Date (mm/dd/yyyy)	*Specimen Type (e.g., stool, wound)* ☐Stool ☐ Blood ☐ Ear discharge/drainage ☐ Urine ☐ Wound ☐ Other: ________________	*Specimen Source Site/Anatomical Source of the Specimen (e.g., blister, right eye, left ear, right ankle)*

Vibrio Culture Result	*If culture completed, Vibrio species identified*
☐ Positive ☐ Negative ☐ Unknown ☐ Not Done	☐ *V. albensis* ☐ *V. cholerae* non-O1, non-O139 ☐ *V. furnissii* ☐ *V. vulnificus* ☐ *V. alginolyticus* ☐ *V. cholerae,* serogroup not specified ☐ *V. metschnikovii* ☐ *Grimontia hollisae* ☐ *V. cholerae* O1 ☐ *V. cincinnatiensis* ☐ *V. mimicus* ☐ *Photobacterium damselae* ☐ *V. cholerae* O139 ☐ *V. fluvialis* ☐ *V. parahaemolyticus* ☐ *Vibrio species* - not identified ☐ Other (specify): ___________________________

Vibrio CIDT Result	*If CIDT, type of diagnostic test*	*If CIDT, name of diagnostic test*	*If CIDT completed, Vibrio species identified*
☐ Positive ☐ Negative ☐ Unknown ☐ Not Done	☐ PCR ☐ Antigen-based ☐ Other (specify): ____________ ☐ Unknown	☐ Biofire FilmArray ☐ Diatherix ☐ Luminex ☐ Nanosphere ☐ Other (specify): __________ ☐ Unknown	☐ *Vibrio* ☐ *Vibrio cholerae*, serogroup not specified ☐ *Vibrio* & *V. cholerae* ☐ *V. parahaemolyticus* ☐ Other (specify): _______________ ☐ Species not identified

If Vibrio cholerae O1 or O139, specify serotype, biotype, and whether toxigenic.

Serotype	*Biotype*
☐ Inaba ☐ Ogawa ☐ Hikojima ☐ Not done ☐ Unk	☐ El Tor ☐ Classical ☐ Not done ☐ Unk

Toxigenic	*If Yes, toxin positive by:*
☐ Yes ☐ No ☐ Unk	☐ ELISA ☐ Latex agglutination ☐ PCR ☐ Other (specify):_____________________

Were other non-Vibrio organisms isolated from the same specimen?	*If Yes, specify organism(s)*
☐ Yes ☐ No ☐ Unk	
Clinical Laboratory Name	*Clinical Laboratory Telephone*

PUBLIC HEALTH LABORATORY TESTING

Was isolate tested at a local public health lab? ☐ Yes ☐ No ☐ Unk	*Local Public Health Laboratory Name*	*Local Laboratory Isolate ID Number*
Was isolate tested at a state public health lab? ☐ Yes ☐ No ☐ Unk	*State Public Health Laboratory Name*	*State Laboratory Isolate ID Number*
Was whole genome sequencing (WGS) completed? ☐ Yes ☐ No ☐ Unk	*WGS ID Number*	*Specify results (e.g., allele code) or attach*

ANTIMICROBIAL SUSCEPTIBILITY TESTING

Antimicrobial susceptibility testing completed? ☐ Yes ☐ No ☐ Unk Attach additional results or upload to the CalREDIE electronic filing cabinet.					
	Ampicillin:	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
	Azithromycin:	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
	Cefoxitin:	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
	Ciprofloxacin:	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
	Tetracycline:	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
	Trimethoprim-sulfamethoxazole:	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
	Other, specify: __________________	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done

First three letters of patient's last name: ☐☐☐

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: UP TO 7 DAYS PRIOR TO ILLNESS ONSET

TRAVEL HISTORY

*Did patient travel **outside county of residence** during the **incubation period**?*
☐ Yes ☐ No ☐ Unk

If Yes, specify all locations and dates below.

TRAVEL HISTORY - DETAILS

Travel Type	Location			Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
	State	Country	Other Location Details (city, resort, etc.)		
☐ Domestic ☐ Unk ☐ International					
☐ Domestic ☐ Unk ☐ International					
☐ Domestic ☐ Unk ☐ International					

TRAVEL HISTORY – REASON FOR TRAVEL (CHOLERA CASES ONLY)

If the patient traveled outside the U.S., what was the reason for travel?
☐ Visiting relatives/friends ☐ Tourism ☐ Medical/disaster relief ☐ Other: ______________________________
☐ Business ☐ Active duty military ☐ Unk

FOOD HISTORY

DID THE PATIENT EAT ANY OF THE FOLLOWING TYPES OF SEAFOOD DURING THE INCUBATION PERIOD? (IF EATEN MULTIPLE TIMES, USE MOST RECENT MEAL.)

Food Item	Yes	No	Unk	If Yes, Specify as Noted
Oysters				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk *Date Last Eaten (mm/dd/yyyy)* *Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM *Eaten raw?* ☐ Yes ☐ No ☐ Unk *Eaten undercooked?* ☐ Yes ☐ No ☐ Unk *Amount Consumed* *Location Purchased (restaurant/store name and address)* *Location Consumed (restaurant/store name and address)* *Were the oysters part of a dish, like chef special, happy hour special, shooters, etc.?* ☐ Yes ☐ No ☐ Unk *If Yes, specify type of dish* *Did any dining partners consume the same seafood?* ☐ Yes ☐ No ☐ Unk *If Yes, did any become ill?* ☐ Yes ☐ No ☐ Unk *Type of Oysters* ☐ Atlantic ☐ Blue Point ☐ Carlsbad ☐ Church Point ☐ Kumamoto ☐ Pacific ☐ Other, specify: ____________________ ☐ Unk *If Unknown, please provide any other details you can remember (Pacific NW, East Coast, Canada, etc.)*
Clams				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk *Date Last Eaten (mm/dd/yyyy)* *Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM *Eaten raw?* ☐ Yes ☐ No ☐ Unk *Eaten undercooked?* ☐ Yes ☐ No ☐ Unk *Amount Consumed* *Location Purchased (restaurant/store name and address)* *Location Consumed (restaurant/store name and address)*

First three letters of patient's last name: | | | |

Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Crab				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk	*Date Last Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Eaten undercooked?* ☐ Yes ☐ No ☐ Unk	*Amount Consumed*
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Lobster				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk	*Date Last Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Eaten undercooked?* ☐ Yes ☐ No ☐ Unk	*Amount Consumed*
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Mussels				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk	*Date Last Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Eaten undercooked?* ☐ Yes ☐ No ☐ Unk	*Amount Consumed*
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Shrimp				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk	*Date Last Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Eaten undercooked?* ☐ Yes ☐ No ☐ Unk	*Amount Consumed*
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Crawfish				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk	*Date Last Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Eaten undercooked?* ☐ Yes ☐ No ☐ Unk	*Amount Consumed*
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Scallops				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk	*Date Last Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Eaten undercooked?* ☐ Yes ☐ No ☐ Unk	*Amount Consumed*
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		

First three letters of patient's last name: | | | |

Food Item	Yes	No	Unk	If Yes, Specify as Noted		
Other shellfish (specify): ___________________				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk	*Date Last Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Eaten undercooked?* ☐ Yes ☐ No ☐ Unk	*Amount Consumed*
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		
Fish (specify): ___________________				*Consumed on multiple dates?* ☐ Yes ☐ No ☐ Unk	*Date Last Eaten (mm/dd/yyyy)*	*Time Eaten (HH:MM AM/PM)* ___ : ___ ☐ AM ☐ PM
				Eaten raw? ☐ Yes ☐ No ☐ Unk	*Eaten undercooked?* ☐ Yes ☐ No ☐ Unk	*Amount Consumed*
				Location Purchased (restaurant/store name and address)		
				Location Consumed (restaurant/store name and address)		

SEAFOOD EXPOSURE / ENVIRONMENTAL HEALTH INVESTIGATION

If seafood is suspected as the source of infection, local environmental health should investigate the source of the seafood and obtain available shellfish tags if oysters or other shellfish were consumed.

What is the status of the Environmental Health investigation? ☐ Completed ☐ In progress ☐ Not conducted	*Is the Seafood Investigation Report Form attached to this report?* ☐ Yes ☐ No ☐ Unk
If patient consumed oysters, clams, mussels, or scallops, are the shellfish tags attached to this report? ☐ Yes ☐ No ☐ Not Applicable ☐ Unk	

EXPOSURES / RISK FACTORS – OTHER (IF EXPOSURE OCCURRED MULTIPLE TIMES, USE MOST RECENT DATE)

DID THE PATIENT HAVE CONTACT WITH ANY OF THE FOLLOWING DURING THE INCUBATION PERIOD?

EXPOSURE/RISK	Yes	No	Unk	If Yes, Specify as Noted	
Body of water				*Water type* ☐ Salt water ☐ Brackish water ☐ Unk ☐ Fresh water ☐ Other:_______________	*Date of Exposure (mm/dd/yyyy)*
				Name and Location of Water	
				Describe exposure (e.g., swimming, surfing, etc.)	
Drippings from raw or live seafood, including handling/cleaning				*Type of Seafood*	*Date of Exposure (mm/dd/yyyy)*
				Describe Exposure (e.g., handling or cleaning)	
Other contact with marine or freshwater life, including stings/bites				*Type of Marine or Freshwater Life*	*Date of Exposure (mm/dd/yyyy)*
				Describe Exposure (e.g., stings or bites)	
Pre-existing wound at site of exposure				*Describe how wound occurred and anatomic site of pre-existing wound*	
New wound sustained at site of exposure				*Describe how wound occurred and anatomic site of new wound*	
Other Exposures of Interest (describe)					
If yes to any of the above skin exposures, was this an occupational exposure? ☐ Yes ☐ No ☐ Unk					

First three letters of patient's last name: | | | |

ILL CONTACTS

Any contacts with similar illness (including household contacts)? ☐ Yes ☐ No ☐ Unk	*If Yes, specify details below.*

ILL CONTACTS – DETAILS

Name 1	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unk
Name 2	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unk

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date Reported (mm/dd/yyyy)*
First Reported By ☐ Clinician ☐ Laboratory ☐ Other (specify):________		*Health education provided?* ☐ Yes ☐ No ☐ Unk	*Restriction / clearance needed?* ☐ Yes ☐ No ☐ Unk

EPIDEMIOLOGICAL LINKAGE

Epi-linked to known case? ☐ Yes ☐ No ☐ Unk	*Contact Name / Case Number*

DISEASE CASE CLASSIFICATION

Case Classification (see case definition on page 9)
☐ Confirmed ☐ Probable ☐ Not a case

OUTBREAK

Part of known outbreak? ☐ Yes ☐ No ☐ Unk	*If Yes, extent of outbreak:* ☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unk ☐ Other (specify):________		
Mode of Transmission ☐ Point source ☐ Person-to-person ☐ Unk ☐ Other:		*Vehicle of Outbreak*	
Pattern 1 ID Number	*Pattern 2 ID Number*	*CDC PulseNet Cluster Code*	*NORS ID*

STATE USE ONLY

State Case Classification
☐ Confirmed ☐ Probable ☐ Not a case ☐ Need additional information

CASE DEFINITION

CHOLERA (Toxigenic *Vibrio cholerae* O1 or O139) (2010)

CLINICAL DESCRIPTION

An illness characterized by diarrhea and / or vomiting; severity is variable.

LABORATORY CRITERIA FOR DIAGNOSIS

- Isolation of **toxigenic** (i.e., cholera toxin-producing) *Vibrio cholerae* O1 or O139 from stool or vomitus, OR
- Serologic evidence of recent infection

CASE CLASSIFICATION

Confirmed

A clinically compatible illness that is laboratory confirmed.

COMMENT

Illnesses caused by strains of *V. cholerae* other than **toxigenic** *V. cholerae* O1 or O139 should not be reported as cases of cholera. The etiologic agent of a case of cholera should be reported as either *V. cholerae* O1 or *V. cholerae* O139.

VIBRIOSIS (2017)

CLINICAL CRITERIA

An infection of variable severity characterized by watery diarrhea, primary septicemia, or wound infection. Asymptomatic infections may occur, and the organism may cause extra-intestinal infection.

LABORATORY CRITERIA FOR DIAGNOSIS

Confirmatory laboratory evidence

Isolation of a species of the family *Vibrionaceae* (other than toxigenic *Vibrio cholerae* O1 or O139, which are reportable as cholera) from a clinical specimen.

Supportive laboratory evidence

Detection of a species of the family *Vibrionaceae* (other than toxigenic *Vibrio cholerae* O1 or O139, which are reportable as cholera) from a clinical specimen using a culture-independent diagnostic test.

EPIDEMIOLOGIC LINKAGE

A clinically compatible case that is epidemiologically linked to a case that meets the supportive or confirmatory laboratory criteria for diagnosis.

CRITERIA TO DISTINGUISH A NEW CASE FROM AN EXISTING CASE

- A case should not be counted as a new case if laboratory results were reported within 30 days of a previously reported infection in the same individual.
- When two or more different species of the family Vibrionaceae are identified in one or more specimens from the same individual, each should be reported as a separate case.

CASE CLASSIFICATION

Confirmed

A case that meets the confirmed laboratory criteria for diagnosis.

Probable

A case that meets the supportive laboratory criteria for diagnosis, or a clinically compatible case that is epidemiologically linked to a case that meets the supportive or confirmatory laboratory criteria for diagnosis.

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

OCCUPATION SETTING

- Childcare / Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Adult film actor / actress
- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory / seasonal worker
- Agriculture - other / unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other / unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - server
- Food service - other / unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - nurse
- Medical - other / unknown
- Military
- Police officer
- Professional, technical, or related profession
- Retired
- Sex worker
- Stay at home parent / guardian
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high school
- Student - college or university
- Student - other / unknown
- Teacher / employee - preschool or kindergarten
- Teacher / employee - elementary or middle school
- Teacher / employee - high school
- Teacher / instructor / employee - college or university
- Teacher / instructor / employee - other / unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other / unknown
- Volunteer
- Other
- Refused
- Unknown