One Health Harmful Algal Bloom System (OHHABS)

Human Form

Form Approved
OMB No. 0920-1105
Expires 03/31/2022

CDC REPORT ID	CDC FORM ID	STATE REPORT ID	HUMAN CASE ID	DATE CREATED

**Note: Create or update a report by appending an environmental form to this human form.

GENERAL INFORMATION

Human Description

Sex: _____ Age (years): _____ State of residence: _____

Dates (MM/DD/YYYY)

Did the person have exposure to algae and/or algal toxins on a single date or multiple dates? *(check one)*

☐ Single date ☐ Multiple dates ☐ Unknown

Date of first exposure: _____ Time: _____ ☐ AM ☐ PM

Date of last exposure: _____ Time: _____ ☐ AM ☐ PM

Date of illness onset: _____ Time: _____ ☐ AM ☐ PM

Date of illness recovery: _____ Time: _____ ☐ AM ☐ PM

Date of death: _____ Time: _____ ☐ AM ☐ PM

Date of interview: _____ Time: _____ ☐ AM ☐ PM

Date of notification to Local, Territorial, Tribal or State Health Authorities _____

Date Remarks

HUMAN EXPOSURE INFORMATION

Location

State(s) where exposure occurred? _____

Count(ies) where exposure occurred? _____

Setting(s) of the exposure? _____

Specific location name _____

Activities

Exposure source (e.g., Water, Air, Food)	**Exposure activity** (e.g., Recreational activities, Personal use)	**Exposure activity description** (e.g., Swimming, Eating shellfish)	**Water type** *(if applicable)* (e.g., Lake, Ocean, Community Water System)	**Food type** *(if applicable)* (e.g., Bass, Grouper, Oysters)	**Duration of activity** (e.g., 30)	**Duration unit** (e.g., Minutes)

*Personal use: water used for activities such as drinking, cooking, bathing, etc.; Non-personal use: water used for activities such as car washing, lawn care, etc.

Exposure Routes and Remarks

What were the route(s) of exposure? *(check all that apply)*

☐ Ingestion ☐ Inhalation ☐ Skin contact ☐ Other *(describe in Remarks)* ☐ Unknown

Exposure Remarks *(e.g., additional description of multiple exposures)*

SIGNS/SYMPTOMS OF ILLNESS AND HEALTH OUTCOMES

Signs/Symptoms of Illness

Sign/Symptom (e.g., Lethargy, Respiratory irritation)	**Time to onset** (e.g., 30)	**Onset unit** (e.g., Minutes)	**Duration of sign/symptom** (e.g., 4)	**Duration unit** (e.g., Hours)	**Recurrence following multiple exposures?** (i.e., Yes/No/Unknown/ Not Applicable)

Was the person still experiencing signs/symptoms at the time of interview?

☐ Yes *(describe in Remarks)* ☐ No ☐ Unknown

Were signs/symptoms consistent with the route(s) of exposure? *(e.g., location of rash consistent with exposed body parts)*

☐ Yes ☐ No *(describe in Remarks)* ☐ Unknown

If a food item was implicated, were the signs/symptoms consistent with foodborne fish/shellfish poisoning?

☐ Yes *(describe in Remarks)* ☐ No ☐ Unknown ☐ Not applicable

Poisoning description *(e.g., Ciguatera Fish Poisoning)* _____

Signs/Symptoms Remarks

Medical Care and Health Outcomes

Did the person receive first aid care from a non-medical provider? *(e.g., park staff)*

☐ Yes ☐ No ☐ Unknown

Did the person visit a healthcare provider? *(i.e., non-emergency)*

☐ Yes ☐ No ☐ Unknown

Did the person go to an emergency department?

☐ Yes ☐ No ☐ Unknown

Was a Poison Control Center contacted?

☐ Yes ☐ No ☐ Unknown

Did the person die?

☐ Yes ☐ No ☐ Unknown

Do you have additional information about medical care or health outcomes for this person?
(Do not include personally identifiable information)

☐ Yes ☐ No

Medical Care and Health Outcomes Remarks

Health History and Differential Diagnosis

Does the person have a history of:	Response (i.e., Yes/No/ Unknown)	If response is Yes, please describe
Chronic respiratory disease, such as asthma or COPD?		
Using tobacco products?		
Chronic skin disease, such as psoriasis or eczema?		
Allergies to food, medication, or other substances?		
Chronic gastrointestinal disease, such as Crohn's disease?		
Chronic kidney disease or failure (e.g., caused by hypertension, diabetes, extended use of NSAIDs)?		
Liver disease, such as hepatitis or cirrhosis?		
Chronic neurologic disease (e.g., caused by diabetes)?		
Was the person immunocompromised due to medication or illness (e.g., transplant recipient, diabetic)?		
Did the person drink any alcohol within 24 hours prior to symptoms?		
Was the person pregnant?		
Was the person taking medications that increased skin sensitivity to the sun (e.g., acne treatment, antibiotics)?		
Did the person frequently take over the counter (OTC) pain medication (e.g., more than 5 times a week)?		
Did the person have an open wound, sores, or broken skin at the time of the exposure?		
Had the person recently been exposed to any communicable diseases that cause similar signs or symptoms?		
Had the person recently been exposed to any environmental irritants that cause similar signs or symptoms (e.g., poison ivy/oak)?		
Were other causes of the illness investigated?		
Were environmental samples (e.g., mushrooms) tested to rule out other possible causes?		

CLINICAL TESTING

Clinical Testing

Were clinical specimens tested?

☐ Yes *(describe in Test Results)* ☐ No ☐ Unknown

What type(s) of clinical testing were done to diagnose the illness or rule out other causes? *(check all that apply)*

☐ Bloodwork ☐ Culture ☐ Fecal analysis ☐ Histopathology
☐ Skin biopsy ☐ Stomach content analysis ☐ Toxicology ☐ Urinalysis
☐ X-ray ☐ None ☐ Other *(describe in Remarks)* ☐ Unknown

Clinical Test Results

Clinical Specimen Number	**1**	**2**	**3**	**4**	**5**
Classification (e.g., Cyanobacteria)					
Genus or toxin (e.g., *Microcystis)*					
Species (e.g., *aeruginosa)*					
Subspecies/ Serotype / Genotype (e.g., f. scripta)					
Detected in clinical specimen? (i.e., Yes/No/ Unknown)					
Detected in which types of specimens? (e.g., Blood)					
Concentration (e.g., 20)					
Unit (e.g., ppm)					
Test type (e.g., ELISA)					

Clinical Testing Remarks (Please include any other clinical testing information—do not include personally identifiable information)

Clinical Testing Remarks

SUPPLEMENTAL INFORMATION

General Remarks (Please include or attach any other relevant information not captured in the form—do not included personally identifiable information)

General Remarks

AUTHOR AND AGENCY INFORMATION

Form Author: _____

Report Author: _____

Reporting Site Name: _____

Agency Name: _____

Agency Contact Name: _____

Agency Contact Title: _____

Agency Contact Phone: _____

Agency Contact Fax: _____

Agency Contact Email: _____