



# One Health Harmful Algal Bloom System (OHHABS)



Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1105). DO NOT MAIL FORMS TO THIS ADDRESS

Form Approved  
OMB No. 0920-1105  
Expires 03/31/2019

CDC REPORT ID	CDC FORM ID	STATE REPORT ID	HUMAN CASE ID	DATE CREATED
<b>**Note: Create or update a report by appending an environmental form to this human form.</b>				
<b>GENERAL INFORMATION</b>				
<b>Human Description</b>				
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? <i>(check one)</i>				
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				
<div></div>				
<b>HUMAN EXPOSURE INFORMATION</b>				
<b>Location</b>				
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)





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

Yes (describe in Remarks)	No	Unknown	Not applicable
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### Signs/Symptoms Remarks

Yes                      No                      Unknown

Yes                      No                      Unknown

Yes                      No                      Unknown

Yes                      No                      Unknown

Yes                      No                      Unknown

Yes No

**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
<b>Classification</b> (e.g., Cyanobacteria)					
<b>Genus or toxin</b> (e.g., <i>Microcystis</i> )					
<b>Species</b> (e.g., <i>aeruginosa</i> )					
<b>Subspecies/ Serotype / Genotype</b> (e.g., f. scripta)					
<b>Detected in clinical specimen?</b> (i.e., Yes/No/Unknown)					
<b>Detected in which types of specimens?</b> (e.g., Blood)					
<b>Concentration</b> (e.g., 20)					
<b>Unit</b> (e.g., ppm)					
<b>Test type</b> (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 include personally identifiable information)

General Remarks

## AUTHOR AND AGENCY INFORMATION

Form Author: \_\_\_\_\_ Agency Contact Name: \_\_\_\_\_

Report Author: \_\_\_\_\_ Agency Contact Title: \_\_\_\_\_

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