

# Campylobacteriosis

\_\_\_\_\_

COUNTY

FOR STATE USE ONLY

# \_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_ case report

confirmed

presumptive

\_\_\_\_/\_\_\_\_/\_\_\_\_ interstate

suspect

Although always a good idea, case investigations are required only when there is suspicion of an outbreak or there are an unusual number of cases

Date investigation initiated \_\_\_\_\_

## CASE IDENTIFICATION

Name \_\_\_\_\_ Phone(s) \_\_\_\_\_  
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address \_\_\_\_\_  
Street City County Zip

\_\_\_\_\_ e-mail address \_\_\_\_\_

ALTERNATIVE CONTACT:  Parent  Spouse  Household Member  Friend  \_\_\_\_\_

Name \_\_\_\_\_ Phone(s) \_\_\_\_\_  
indicate home (H); work (W); message (M)

Address \_\_\_\_\_  
Street City Zip

SOURCES OF REPORT (check all that apply)

Lab  Infection Control Practitioner

Physician  \_\_\_\_\_

Name \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
(first report)

Primary M.D. \_\_\_\_\_  
(if different)

Phone \_\_\_\_\_ OK to talk to patient?

## DEMOGRAPHICS

SEX  
 female  male

HISPANIC  yes  no  unknown

RACE

White  American Indian

Black  Asian/Pacific Islander

unknown  refused to answer

other \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_  
m d y

or, if unknown, AGE \_\_\_\_\_

Worksites/school/day care center \_\_\_\_\_

Occupations/grade \_\_\_\_\_

## BASIS OF DIAGNOSIS

### CLINICAL DATA

Symptomatic:  yes  no  unk

if yes, ONSET on \_\_\_\_/\_\_\_\_/\_\_\_\_  
m d y

Check all that apply:

diarrhea  yes  no  unk

bloody diarrhea  yes  no  unk

Hospitalized:  yes  no  unk

name of hospital \_\_\_\_\_

date of admission \_\_\_\_/\_\_\_\_/\_\_\_\_  
m d y

date of discharge \_\_\_\_/\_\_\_\_/\_\_\_\_  
m d y

Transferred to/from another hospital:

yes  no  unk

transfer hospital name \_\_\_\_\_

Outcome:  survived  died  unk

date of death \_\_\_\_/\_\_\_\_/\_\_\_\_  
m d y

### LABORATORY DATA

Culture confirmed:  yes  no

if yes, Lab \_\_\_\_\_

Specimen:  stool

blood

\_\_\_\_\_

Specimen collected \_\_\_\_/\_\_\_\_/\_\_\_\_  
m d y

Isolate submitted to PHL?

yes  no  unk

PHL specimen # \_\_\_\_\_

Species:  *C. jejuni*

other \_\_\_\_\_

unk

### EPI-LINKAGE

During the exposure period, was the patient...

associated with a known outbreak?  yes  no  unk

a close contact of a **confirmed** or **presumptive** case?  yes  no  unk

Has the above case been reported?  yes  not yet

Specify nature of contact:

household  sexual  daycare  \_\_\_\_\_

if yes to any question, specify relevant names, dates, places, etc:



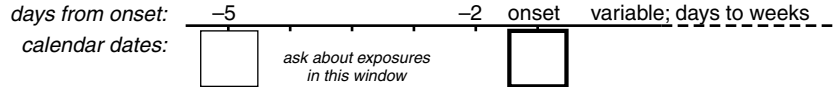
PATIENT'S NAME >

**INFECTION TIMELINE**

**EXPOSURE PERIOD**

**COMMUNICABLE PERIOD**

Enter onset date in heavy box.  
Count back to figure the probable exposure period.



**POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD**

Skip this section if case is already epi-linked.

- no risk factors could be identified
- patient could not be interviewed

- yes no
- e   other unpasteurized milk products
- f   food at restaurants (e.g., queso fresco)
- g   food at gatherings (potlucks, events)

- yes no
- i   livestock, poultry
- j   persons with diarrheal illness
- k   diapered children or adults
- l   occupational exposure to excreta
- m   travel outside the U.S. to \_\_\_\_\_
- n   recreational water exposure (lakes, rivers, pools, etc.)

**SUSPECT FOODS**

- yes no
- a   rare/undercooked poultry
- b   handling/preparation of poultry carcass
- c   raw/rare meat
- d   raw/unpasteurized milk

**OTHER POTENTIAL SOURCES**

- yes no
- h   household pets, especially puppies and kittens
- o if yes, did pet have diarrhea?  yes  no

Provide details about possible sources and risk factors

**CASE-CONTACT MANAGEMENT AND FOLLOW-UP**

Case education provided?  yes  no  unknown

**HOUSEHOLD ROSTER**

name	age	occupation	diarrhea			onset date m/d/y	education provided			comments
			yes	no	unk		yes	no	unk	
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does the case know about anyone else with a similar illness?  yes  no  could not be interviewed  
if yes, give names, onset dates, contact information, and other details.

During the communicable period, did the case prepare food for any public or private gatherings?  yes  no if yes, provide details below.

If the case or household contact is a food handler, HCW with direct patient contact, or works at or attends daycare, provide details about site, job description, dates worked/attended during communicable period (if applicable), supervisor, etc.

- Does the patient attend daycare or nursery school?  yes  no
- If yes: Is the patient in diapers?  yes  no
- Are other children or staff ill?  yes  no

**SUMMARY OF FOLLOW-UP AND COMMENTS.** Provide details as appropriate.

- hygiene education provided
- work or daycare restriction for case
- daycare inspection
- work or daycare restriction for household member
- restaurant inspection
- investigation of raw milk dairy
- \_\_\_\_\_



**ADMINISTRATION**

Campylobacteriosis/August 2005

Remember to copy patient's name to the top of this page.

Completed by \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_ Case report sent to OHS on \_\_\_/\_\_\_/\_\_\_ Investigation sent to OHS on \_\_\_/\_\_\_/\_\_\_