

Salmonellosis

COUNTY

FOR STATE USE ONLY

____/____/____ case report

- confirmed
- presumptive
- suspect

____/____/____ interstate

DO NOT USE FOR TYPHOID FEVER

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 _____ Language spoken _____

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 _____

- Specimens: stool
 blood
 urine

Specimen collected ____/____/____
m d y

Isolate submitted to PHL?
 yes no unk

PHL specimen # _____

Serotype _____

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:

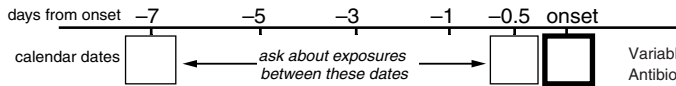


INFECTION TIMELINE

EXPOSURE PERIOD

COMMUNICABLE

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



Variable — until elimination of fecal excretion (days to months).
Antibiotic therapy may prolong carriage.

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

SUSPECT FOODS

- yes no
- a rare/raw meat or poultry
 - b raw or lightly cooked eggs (runny yolks) or foods made with raw eggs (sauces; home-made eggnog, ice cream, mayonnaise, etc.)

- yes no
- c raw/unpasteurized milk
 - d other unpasteurized milk products
 - e food at restaurants
 - f food at gatherings (potlucks, events)
 - g sprouts (alfalfa, clover, bean, ...)

OTHER POTENTIAL SOURCES

- yes no
- j reptiles (lizards, snakes, turtles)

- yes no
- k other pets, including birds, exotics
 - i livestock, poultry (including baby chicks)
 - m persons with diarrheal illness
 - n diapered children or adults
 - o occupational exposure to human excreta
 - t handled natural or raw pet treats
 - p travel outside the U.S. to _____
 - q other travel to _____
 - r _____

Provide details (places, dates) about possible sources and risk factors checked above.

CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER

name	age	occupation	diarrhea			onset date			education provided			comments
			yes	no	unk	m	d	y	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
- follow-up of other household member(s)
- restaurant inspection
- investigation of raw milk dairy
- _____

ADMINISTRATION

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

Completed by _____ Date _____ Phone _____ Initial report sent to OHS on ___/___/___

Case investigation sent to OHS on ___/___/___

