Botulism

COUNTY

for state use only Orpheus # ☐ confirmed

___/___/___ case report ☐ presumptive ☐ suspect

☐ Foodborne ☐ Intestinal: Infant ☐ Intestinal: adult ☐ Wound ☐ _____

Date investigation initiated: ____/____/____ Time _____:_____ ☐ am ☐ pm

CASE IDENTIFICATION

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

Address _____
Street City Zip

_____e-mail address _____

ALTERNATIVE CONTACT: ☐ Parent ☐ Spouse ☐ Household Member ☐ Friend ☐ _____
indicate home (H); work (W); message (M)

Name _____Phone(s) _____

Address_____
Street City Zip

SOURCES OF REPORT *(check all that apply)*

☐ Lab ☐ Infection Control Practitioner

☐ Physician ☐ _____

Name _____

Phone _____

Date ___/___/___ Time ___:___
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient? ☐

DEMOGRAPHICS

SEX ☐ female ☐ male

DATE OF BIRTH ____/____/____
m d y

or, if unknown, AGE _____

HISPANIC ☐ yes ☐ no ☐ unknown

RACE

☐White ☐ American Indian

☐ Black ☐ Asian ☐ Pacific Islander

☐ unknown ☐ refused to answer

☐ other _____

Worksites/school/day care center_____

_____

Occupations/grade_____

BASIS OF DIAGNOSIS

EPI-LINK-

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 ☐ meal companion ☐ other_____

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

CLINICAL DATA

Date of first symptoms ____/____/____ Onset hour (if known) _____
m d y military time

Hospitalized: ☐ yes ☐ no ☐ unk

name of hospital _____

date of admission ____/____/____

date of discharge ____/____/____

Transferred to/from another hospital:

☐ yes ☐ no ☐ unk to: _____

Outcome: ☐ survived ☐ died ☐ unk

date of death ____/____/____

Recent medication history (within 30 days of illness):

phenothiazine ☐ yes ☐ no

aminoglycoside ☐ yes ☐ no

anticholinergic ☐ yes ☐ no

Botox or mycobloc ☐ yes ☐ no

other _____

abdominal pain	☐ yes	☐ no	☐ unk
nausea	☐ yes	☐ no	☐ unk
vomiting	☐ yes	☐ no	☐ unk
diarrhea	☐ yes	☐ no	☐ unk
blurred vision	☐ yes	☐ no	☐ unk
diplopia	☐ yes	☐ no	☐ unk
dizziness	☐ yes	☐ no	☐ unk
slurred speech	☐ yes	☐ no	☐ unk
sensation of “thick tongue”	☐ yes	☐ no	☐ unk
change in sound of voice	☐ yes	☐ no	☐ unk
hoarseness	☐ yes	☐ no	☐ unk
dry mouth	☐ yes	☐ no	☐ unk
difficulty swallowing	☐ yes	☐ no	☐ unk
shortness of breath	☐ yes	☐ no	☐ unk
subjective weakness	☐ yes	☐ no	☐ unk
fatigue	☐ yes	☐ no	☐ unk
paresthesia	☐ yes	☐ no	☐ unk

if yes, describe _____

PATIENT'S NAME ◦

BASIS OF DIAGNOSIS (continued)

Signs:

vital signs on presentation: temp _____ BP_____/_____ HR _____/min RR _____/min

altered mental state	☐ yes	☐ no	☐ unk	
extrocular palsy	☐ yes	☐ no	☐ unk	☐bilateral
ptosis (drooping eyelids)	☐ yes	☐ no	☐ unk	☐ bilateral
pupils: dilated	☐ yes	☐ no	☐ unk	☐ bilateral
constricted	☐ yes	☐ no	☐ unk	☐bilateral
reactive	☐ yes	☐ no	☐ unk	☐ bilateral
facial paralysis	☐ yes	☐ no	☐ unk	☐ bilateral
palatal weakness	☐ yes	☐ no	☐ unk	☐ bilateral
impaired gag reflex	☐ yes	☐ no	☐ unk	☐bilateral
wound	☐ yes	☐ no	☐ unk	

if yes, describe _____ site: _____ Date of injury (if known) ___/___/___

sensory deficits ☐ yes ☐ no ☐ unk

if yes, describe _____

abnormal DTRs (deep tendon reflexes) ☐ yes ☐ no ☐ unk

if yes, describe _____

weakness/paralysis:

Indicate if weakness or paralysis was noted before antitoxin release:

Extremities:

upper distal	☐ yes	☐ no	☐ unk	☐bilateral
upper proximal	☐ yes	☐ no	☐ unk	☐bilateral
lower distal	☐ yes	☐ no	☐ unk	☐bilateral
lower proximal	☐ yes	☐ no	☐ unk	☐bilateral

If weakness present, describe progression of the weakness/paralysis:

ascending ☐

descending ☐

unknown ☐

other _____

Morbidity:

List morbidity present before antitoxin release:

admitted to intensive care:	☐ yes	☐ no	☐ unk
ventilator:	☐ yes	☐ no	☐ unk
tracheostomy:	☐ yes	☐ no	☐ unk
other:	☐ yes	☐ no	☐ unk

Notes on Botulism Antitoxin

Physician contact _____ phone _____

Pharmacist contact _____ phone _____

Hospital _____

Antitoxin released? ☐ yes ☐ no

Antitoxin administered? ☐ yes ☐ no

if yes, date ____/____/____ (m / d / y) time _____

OPHD epidemiologist _____

CDC contact _____ phone _____

Details of antitoxin shipping:

PATIENT'S NAME ◦

BASIS OF DIAGNOSIS

LABORATORY DATA

Lumbar puncture: date ____/____/____ (m/d/y) ☐ not done

RBC: _____/µl WBC: _____ /µl Protein _____ mg/dl Glucose _____ mg/dl

Tensilon® test: date ____/____/____ (m/d/y) ☐ not done

Results: _____

Electromyography (EMG): date ____/____/____ ☐ suggestive of botulism ☐ not consistent with botulism ☐ unknown ☐ not done

Muscle group: _____

Rapid repetitive stimulation: _____ ☐ not done

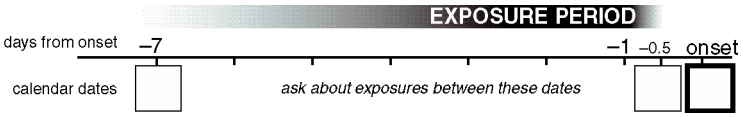
Stimulated at _____ Hz

	collection date	pos	neg	n.d.	PHL #
Serum for toxin:	____/____/____	☐	☐	☐	_____
Stool for toxin:	____/____/____	☐	☐	☐	_____
Stool culture:	____/____/____	☐	☐	☐	_____
Food: _____	____/____/____	☐	☐	☐	_____
Other: _____	____/____/____	☐	☐	☐	_____

toxin type: ☐A ☐ B ☐ E ☐ Other _____

INFECTION TIMELINE

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



POSSIBLE SOURCE(S) OF EXPOSURE

Skip this section if case is already epi-linked.

Provide details about possible sources and risk factors; for suspect products, include details on brand, size, lot numbers, expiration dates, where purchased; when consumed, &c.

SUSPECT FOODS

	yes	no	
a	☐	☐	home-canned food
b	☐	☐	commercially canned food
c	☐	☐	sausage or other preserved meats
d	☐	☐	preserved fish
e	☐	☐	items stored in oil (spice-flavored oils)
f	☐	☐	baked potato stored in foil
g	☐	☐	infant formula
h	☐	☐	injected drug use

☐ heroin ☐ cocaine ☐ methamphetamine
☐ other _____ ☐ unknown

PATIENT'S NAME ◦

CONTACT MANAGEMENT AND FOLLOW-UP

Household members or other contacts with similar illness or suspect meal

name	age	phone number	neurologic symptoms	onset	education provided	comments
			yes ☐ no ☐ unk ☐		yes ☐ no ☐ unk ☐	
			☐ ☐ ☐		☐ ☐ ☐	
			☐ ☐ ☐		☐ ☐ ☐	
			☐ ☐ ☐		☐ ☐ ☐	
			☐ ☐ ☐		☐ ☐ ☐	

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.

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

- ☐ referral to physician
- ☐ follow up of others who ate suspect food
- ☐ referral of suspect food to regulatory agency
- ☐ restaurant inspection
- ☐ education on proper canning technique provided
- ☐ _____

ADMINISTRATION

Date and time case report sent to OPHD: ____/____/____ ____ ☐am ☐pm

Completed by _____ Date _____ Phone _____ Investigation sent to OPHD on ____/____/____

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