

Shigellosis

ORPHEUS ID

Confirmed Suspect
 Presumptive No case
Subtype: _____

Name _____
LAST, first, initials (a.k.a.)

County _____

Address _____
Street City Zip

Phone number _____ / _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

E-mail _____

ALTERNATE CONTACT _____

Name _____ Phone(s) _____
LAST, first, initials home (H), work (W), cell (C), message (M)

Special housing	
<input type="checkbox"/> Nursing home/Asst Living	<input type="checkbox"/> YES house
<input type="checkbox"/> Homeless	<input type="checkbox"/> Homeless shelter
<input type="checkbox"/> Prison/jail	<input type="checkbox"/> Job Corps
<input type="checkbox"/> Foster home	<input type="checkbox"/> Treatment center
<input type="checkbox"/> Hospital	<input type="checkbox"/> Chemawa Indian School
<input type="checkbox"/> Nursing home	<input type="checkbox"/> No address on file
<input type="checkbox"/> Drug treatment/shelter	<input type="checkbox"/> Women's shelter
<input type="checkbox"/> Other (specify) _____	

DEMOGRAPHICS

DOB ____/____/____ if DOB unknown, AGE ____ Sex Female Male Preg Y N UNK

Language _____ Country of birth _____ refugee

Past year housing (check one) Stably housed Homeless Unstably housed Declined Unknown

Worksites/school/day care center _____ Occupation/grade _____

RACE, ETHNICITY, LANGUAGE, AND DISABILITY (REALD)

RACE AND ETHNICITY

How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?

Which of the following best describes your racial or ethnic identity? *Check all that apply.*

Amer Indian/

Alaska Native

- American Indian
- Alaska Native
- Canadian Inuit, Metis First Nation
- Indigenous Mexican Central American South American

Hispanic or Latino/a/x

- Central American
- Mexican
- South American
- Other Hispanic or Latino/a/x

Asian

- Asian Indian
- Chinese
- Filipino/a
- Hmong
- Japanese
- Korean
- Laotian
- South Asian
- Vietnamese
- Other Asian

If you selected more than one racial or ethnic identity, circle the one that **best** represents your racial or ethnic identity. If you have **more than one** primary racial or ethnic identity please check here.

Native Hawaiian/ Pacific Islander

- Guamanian
- Chamorro
- Micronesian/Marshalese/Palaun (COFA)
- Native Hawaiian
- Samoan
- Tongan
- Other Pacific Islander

Black or African American

- African American
- African (Black)
- Caribbean (Black)

Middle Eastern

- Northern African
- Middle Eastern

White

- Eastern European
- Slavic
- Western European
- Other White

Other Categories

- Other (please list) _____
- Don't know
- Don't want to answer

PROVIDERS, FACILITIES AND LABS (COMPLETE ALL THAT APPLY)

Reporter Type	Reporter Name/Phone
Clinical Office	_____
Hospital	_____
ER	_____
Laboratory	_____
Care Facility	_____

Reporter Type	Reporter Name/Phone
Assisted Living	_____
Group home	_____
Long-term acute care	_____
Nursing home	_____
Inpatient rehab	_____

Ok to contact patient (only list once)

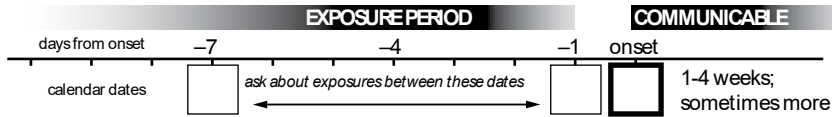
Local Epi _____

Date report received by LPHA ____/____/____ LPHA completion date ____/____/____ State completion date ____/____/____



INFECTIION TIMELINE

Enter onset date in heavy box.
Count back to figure the prob-
able exposure period.



Ask about exposures for
the 7 days prior to onset
date.

Interviewed yes no Interview date(s) _____ Interviewed by _____

Who patient provider parent other _____

Reason not interviewed (choose one)

- not indicated unable to reach out of jurisdiction deceased refused
 medical record review physician interview

BASIS OF DIAGNOSIS

CLINICAL DATA

- Onset indeterminate
 Symptomatic yes no ref unk
first symptoms _____
first vomiting or diarrhea _____
illness duration (days) _____

Check all that apply: (Provide details in Notes section.)

- Diarrhea yes no ref unk
Bloody diarrhea yes no ref unk
Fever yes no ref unk

LABORATORY DATA

- none
Testing Lab _____
Originating Lab _____
Specimen collection date ____/____/____ Specimen ID _____
Result date ____/____/____

- Specimen source
 blood stool urine
 other specify in Notes _____

- Test type and result
 culture pos neg unk
 PCR pos neg unk
 Shigatoxin PCR pos neg unk
 other _____ pos neg unk

PUBLIC HEALTH LAB DATA

- Isolate sent to OSPHL yes no unk
PHL specimen ID _____
Species
 sonnei flexnari boydii dysenteriae
subtype _____

OUTCOMES

- Deceased no yes Date of death ____/____/____
Cause: disease-related treatment-related
 not disease-related unk
 other _____

Hospitalized: yes no unk

- Hospital Name _____
Chart number _____ ICU
Admit date ____/____/____ Discharge date ____/____/____
Status: Check one: alive dead unk transfer

Hospitalized: yes no unk

- Hospital Name _____
Chart number _____ ICU
Admit date ____/____/____ Discharge date ____/____/____
Status: Check one: alive dead unk transfer

Notes

TREATMENT

Was patient treated with antibiotics or anti-motility drugs for this illness? yes (if yes, list below) no unk

Drug name	size/dose/frequency	start date	end date
_____	_____	____/____/____	____/____/____
_____	_____	____/____/____	____/____/____
_____	_____	____/____/____	____/____/____

Comments: _____



RISKS

Provide details as appropriate. Include names and locations about possible sources and risk factors in Notes.

yes no ref unk

- food at restaurants, fast food, vendors
- food at other gatherings (events, potlucks)
- work exposure to human or animal excreta
- recreational water exposure (swimming pools, hot tubs, water parks, lakes, rivers, streams, fountains, ocean, backyard splash pools, etc.)
If yes, please specify _____
- exposure to kids in day care settings
- other household members attend or work in day care
- contact with diapered or incontinent people (kids or adults)
- history of homelessness
- oral-anal sexual contact
- contact with other ill people with vomiting or diarrhea
If yes, please specify _____
- history of homelessness
- sex with men
- sex with women
- sex with both men and women
- other risks (specify in notes)

yes no ref unk

- travel outside home area
- travel outside Oregon
- travel outside U.S.

If yes, provide dates: ___/___/___ to ___/___/___

Destination(s) _____

Purpose(s) _____

Travel mode(s) _____

Companion(s) _____

NOTES: Provide details as needed.

Notes: Provide information about other risks as needed.

EPI-LINKAGE

At time of report case appears to be

- sporadic
- household with 2 or more cases
- multi-household or cluster

Outbreak ID _____

Case appears to be:

- primary secondary, (e.g. not first in household)

If a contact of confirmed or presumptive case, identify nature of contact

- household friend sexual day care
- coworker other _____

Has the above case been reported? yes no unk

Exposure date ___/___/___

If contact with other case(s) in same outbreak or cluster, specify name, age, county

Notes

CASE-CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER

Name	DOB/Age	Sex	Relation to case	Occupation	Education provided	Phone number	Interview date	Sick
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> household <input type="checkbox"/> sexual <input type="checkbox"/> coworker	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	___/___/___	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> household <input type="checkbox"/> sexual <input type="checkbox"/> coworker	_____	<input type="checkbox"/> Y	_____	___/___/___	<input type="checkbox"/> Y <input type="checkbox"/> N
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> household <input type="checkbox"/> sexual <input type="checkbox"/> coworker	_____	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	___/___/___	<input type="checkbox"/> Y <input type="checkbox"/> N

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

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

- case education provided date: ___/___/___ _____
- household member is a health care worker _____
- case knows someone with a similar illness _____
- during communicable period, case prepared food for public or private gathering _____
- case is a resident of a long-term care facility _____
- case in diapers _____
- case works at or attends day care _____
- work or school restriction for case _____
- work or daycare restriction for household members _____
- follow-up of household members _____
- day care inspection _____
- restaurant inspection _____
- testing of water supply done date: ___/___/___ _____

Notes