Infant Botulism required variables are in **bold**. Answers are: Yes, No, Unknown to case

DOH 210-018 (Rev.11/2022)
EMPLOYMENT AND SCHOOL

Employed [ ] Yes [ ] No [ ] Unk
Occupation _____________________________________ Industry ___________________________
Employer _____________________________________ Work site ___________________________ City ________________________

Student/Day care [ ] Yes [ ] No [ ] Unk
Type of school [ ] Preschool/day care [ ] K-12 [ ] College [ ] Graduate School [ ] Vocational [ ] Online [ ] Other
School name ___________________________ School address ___________________________
City/State/County __________________________ Zip ________ Phone number ___________ Teacher’s name ___________

COMMUNICATIONS

Primary HCP name _____________________________________ Phone ______________________________________
OK to talk to patient (If Later, provide date) [ ] Yes [ ] Later ___/___/___ [ ] Never
Date of interview attempt ___/___/___ [ ] Complete [ ] Partial [ ] Unable to reach [ ] Patient could not be interviewed
Alternate contact: [ ] Parent/Guardian [ ] Spouse/Partner [ ] Friend [ ] Other __________________________
Name ________________________________________ Phone _______________________________________

Outbreak related [ ] Yes [ ] No LHJ Cluster ID _______________ Cluster Name _______________________________

CLINICAL INFORMATION

Complainant ill [ ] Yes [ ] No [ ] Unk
Symptom Onset ___/___/___ [ ] Derived
Diagnosis date ___/___/___
Illness duration _______ Days [ ] Weeks [ ] Months [ ] Years [ ] Illness is still ongoing [ ] Yes [ ] No [ ] Unk

Toxin type: __________

Clinical Features

[ ] Yes [ ] No [ ] Unk
Ptosis (drooping eyelids)
Cry weak or altered
Constipation
Poor feeding
Head drooping
Failure to thrive
Floppy or weak infant
Progressive weakness
Progressive symmetric descending paralysis
Impaired respiration distress

Predisposing Conditions

[ ] Yes [ ] No [ ] Unk
Gastric surgery or gastrectomy in past

Hospitalization

[ ] Yes [ ] No [ ] Unk
Hospitalized at least overnight for this illness
Facility name ___________________________
Hospital admission date ___/___/___ Discharge ___/___/___ HRN ___________
Disposition [ ] Another acute care hospital [ ] Died in hospital
[ ] Long term acute care facility [ ] Non-healthcare (home) [ ] Unk
[ ] Other

Admitted to ICU [ ] Yes [ ] No [ ] Unk
Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
Mechanical ventilation or intubation required [ ] Yes [ ] No [ ] Unk
Still hospitalized As of ___/___/___

[ ] Yes [ ] No [ ] Unk
Died of this illness
Death date ___/___/___ Please fill in the death date information on the Person Screen
Autopsy performed [ ] Yes [ ] No [ ] Unk

Death certificate lists disease as a cause of death or a significant contributing condition
Location of death [ ] Outside of hospital (e.g., home or in transit to the hospital) [ ] Emergency department (ED)
[ ] Inpatient ward [ ] ICU [ ] Other __________________________

Laboratory

[ ] Yes [ ] No [ ] Unk
Food specimens submitted for testing Describe:

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**LAB RESULTS**

Lab report information
- Lab report reviewed – LHJ
- WDRS user-entered lab report note

Submitter _______________________________________
Performing lab for entire report _______________________________________
Referring lab _______________________________________

Specimen
- Specimen identifier/accession number
- Specimen collection date ___/___/___ Specimen received date ___/___/___

**WDRS specimen type**
WDRS specimen source site _______________________________________
WDRS specimen reject reason _______________________________________

Test performed and result
- WDRS test performed
- WDRS test result, coded
- WDRS test result, comparator
- WDRS test result, numeric only (enter only if given, including as necessary Comparator and Unit of measure)
- WDRS unit of measure
- Test method
- WDRS interpretation code
- Test result – Other, specify
- WDRS result summary
- Test result status
- Final results; Can only be changed with a corrected result
- Preliminary results
- Record coming over is a correction and thus replaces a final result
- Results cannot be obtained for this observation
- Specimen in lab; results pending
- Result date ___/___/___

Upload document

Ordering Provider
- WDRS ordering provider

Ordering facility
- WDRS ordering facility name

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