



Botulism, Foodborne

County _____

Case name (last, first) _____
 Birth date ___/___/___ Sex at birth F M Other Alternate name _____
 Phone _____ Email _____
 Address type Home Mailing Other Temporary Work
 Street address _____
 City/State/Zip/County _____
 Residence type (incl. Homeless) _____ WA resident Yes No

ADMINISTRATIVE

Investigator _____
 LHJ Case ID (optional) _____
LHJ notification date ___/___/___
Classification Classification pending Confirmed
 Not reportable Probable Ruled out Suspect
 Investigation status
 In progress
 Complete
 Complete – not reportable to DOH
 Unable to complete Reason _____
Investigation start date ___/___/___
 Investigation complete date ___/___/___
Case complete date ___/___/___
 Outbreak related Yes No
 LHJ Cluster ID _____ Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ Years Months
Ethnicity Hispanic or Latino Not Hispanic or Latino Unk
Race (check all that apply) Unk Amer Ind/AK Native
 Asian Black/African Amer Native HI/other PI
 White Other _____
 Primary language _____
 Interpreter needed Yes No Unk
 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 _____

REPORT SOURCE

Initial report source _____
 LHJ _____
 Reporter organization _____
 Reporter name _____
 Reporter phone _____
 All reporting sources (list all that apply)

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 _____
 Contact name _____
 Contact phone _____

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

- | Y | N | Unk | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bulbar weakness (cranial nerve abnormalities) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diplopia (double vision) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ptosis (drooping eyelids) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swallowing or speech difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dyspnea (shortness of breath) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Progressive symmetric descending paralysis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory distress |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea (3 or more loose stools within a 24 hour period) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abscess, infected lesion, wound, or break in skin |

Predisposing Conditions

Y N Unk

Gastric surgery or gastrectomy in past

Hospitalization

Y N 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

Long term care facility Non-healthcare (home) Unk

Other _____

Still hospitalized As of ___/___/___

Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___

Mechanical ventilation or intubation required

Y N Unk

Died of this illness Death date ___/___/___ Please fill in the death date information on the Person Screen

Autopsy performed

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

Y N Unk

Food specimens submitted for testing

RISK AND RESPONSE (Ask about exposures 12 hours - 7 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> County/City _____ <input type="checkbox"/> State _____ <input type="checkbox"/> Country _____ <input type="checkbox"/> Other _____
Destination name	_____	_____	_____
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___

Risk and Exposure Information

Y N Unk

Is case a recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Country _____

Does the case know anyone else with similar symptoms or illness

Onset date, shared meals, relationship, etc. _____

Home canned food

Foods stored in oil (e.g., garlic, sun dried tomatoes)

Dried, preserved, or traditionally prepared meat (e.g., sausage, salami, jerky)

Preserved, smoked, or traditionally prepared fish or marine products

Vacuum packed (modified atmosphere packaging) foods

Known contaminated food product Source (e.g., beans, tomatoes) _____

Processed how Home canned Commercially canned Fermented Boiled Not specified/Unk

Not marked Other

Specify _____

Suspected exposure to botulism contaminated food Specify _____

Injected drugs not prescribed by a doctor, even if only once or a few times Describe _____

Contaminated wound during the 2 weeks before onset of symptoms

Source of botulism identified Specify _____

Food exposure timeframe: 12 hours to 7 days prior to onset of illness. Ask about detailed food exposures only if no risk exposure is identified, but Foodborne Botulism is suspected

Sources of food IN home - During exposure timeframe did you (your child) eat foods from:

(1) Grocery stores or supermarkets

(2) Home delivery grocery services (CSA, grocery delivery, Amazon Fresh, Peapod, etc)

(3) Fish or meat specialty shops (butcher shop, etc)

(4) Warehouse stores (Costco, Sam's Club, etc.)

(5) Meal delivery services (Blue Apron, Meals on Wheels, Schwan's, NutriSystem, etc)

(6) Live animal market, custom slaughter facility

(7) Small markets/mini markets (convenience stores, gas stations, etc)

(8) Health food stores or co-ops

(9) Ethnic specialty markets (Mexican, Asian, Indian)

(10) Farmers markets, roadside stands, open-air markets, food purchased directly from a farm

(11) Other _____

Type of Business (enter number next to choices above)	Business name	Address/location

Sources of food outside home - During exposure timeframe did you (your child) eat foods from:

- | | |
|--|--|
| <input type="checkbox"/> (1) Fast casual (Chipolte, Panera, etc) | <input type="checkbox"/> (10) Chinese, Japanese, Vietnamese, other Asian-style |
| <input type="checkbox"/> (2) Fast food (McDonald's, Burger King, Wendy's) | <input type="checkbox"/> (11) All-you-can-eat buffet |
| <input type="checkbox"/> (3) Sandwich shop, deli | <input type="checkbox"/> (12) Breakfast, brunch, diner, or café |
| <input type="checkbox"/> (4) Jamaican, Cuban, or Caribbean | <input type="checkbox"/> (13) Middle Eastern, Greek/Mediterranean, Arabic, Lebanese, African |
| <input type="checkbox"/> (5) Ready-to-eat prepared food from grocery or deli | <input type="checkbox"/> (14) Any takeout from a restaurant |
| <input type="checkbox"/> (6) An event where food was served (catered event, festival, church, or community meal) | <input type="checkbox"/> (15) Healthy restaurant (vegetarian, vegan, salad-based) |
| <input type="checkbox"/> (7) Mexican, Salvadorian, other Hispanic/Latino-style | <input type="checkbox"/> (16) Salad bar at a grocery store or restaurant |
| <input type="checkbox"/> (8) Food trucks, food stalls/stands | <input type="checkbox"/> (17) Other _____ |
| <input type="checkbox"/> (9) School, hospital, senior center, or other institutional setting | |

Type of Business (enter number next to choices above)	Restaurant/venue name	Date	Time of meal (Breakfast, Brunch, Lunch, Happy Hour, Dinner, Other)	Food ordered/eaten	Address/location
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		
			<input type="checkbox"/> Bfast <input type="checkbox"/> Bru <input type="checkbox"/> Lun <input type="checkbox"/> HH <input type="checkbox"/> Din <input type="checkbox"/> Other		

Y M N Unk

Any food sampled (grocery, warehouse stores, food court, etc.) _____

Exposure and Transmission Summary

Y N Unk

Epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours)

Ingestion of the same food as persons who have laboratory-confirmed botulism

Likely geographic region of exposure In Washington – county _____ Other state _____
 Not in US - country _____ Unk

International travel related During entire exposure period During part of exposure period No international travel

Suspected exposure type Foodborne Unk Other _____
 Describe _____

- Suspected exposure setting Day care/Childcare School (not college) Doctor's office Hospital ward Hospital ER
 Hospital outpatient facility Home Work College Military Correctional facility Place of worship
 Laboratory Long term care facility Homeless/shelter Social event Large public gathering Restaurant
 Hotel/motel/hostel Other _____

Describe _____

Exposure summary

Public Health Issues

Y N Unk

- Follow-up of others who ate suspect food Date initiated ___/___/___

Public Health Interventions/Actions

Y N Unk

- Restaurant inspection Name/location _____
 Education on proper canning technique provided
 Commercial product implicated
 Inform appropriate regulatory agency of implicated commercial food product
 Initiate trace-back investigation
 Letter sent Date ___/___/___ Batch date ___/___/___
 Any other public health action

TREATMENT

Y N Unk

- Did patient receive prophylaxis/treatment
Specify antitoxin _____ Treatment start date ___/___/___ Treatment end date ___/___/___
Other medication _____

NOTES

LAB RESULTSLab 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 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 Positive Negative Indeterminate Equivocal Test not performed PendingTest 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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____