



# Botulism, Infant

County \_\_\_\_\_

Case name (last, first) \_\_\_\_\_

Birth date \_\_\_/\_\_\_/\_\_\_ Age at symptom onset \_\_\_\_\_  Years  Months

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  Investigation in progress  Not reportable  Probable  Ruled out  Suspect

Investigation status

Complete  Complete – not reportable to DOH  Unable to complete Reason \_\_\_\_\_  In progress

Dates: **Investigation start** \_\_\_/\_\_\_/\_\_\_ **Investigation complete** \_\_\_/\_\_\_/\_\_\_ **Record complete** \_\_\_/\_\_\_/\_\_\_ **Case complete** \_\_\_/\_\_\_/\_\_\_

## REPORT SOURCE

**Initial report source** \_\_\_\_\_ LHJ \_\_\_\_\_

Reporter organization \_\_\_\_\_

Reporter name \_\_\_\_\_ Reporter phone \_\_\_\_\_

All reporting sources (list all that apply) \_\_\_\_\_

## DEMOGRAPHICS

Sex at birth:  Female  Male  Other  Unknown

Do you consider yourself (your child) Hispanic, Latino/a, or Latinx?

**Ethnicity**  Hispanic, Latino/a, Latinx  Non-Hispanic, Latino/a, Latinx  Patient declined to respond  Unknown

What race or races do you consider yourself (your child)? You can be as broad or specific as you'd like (check all responses):

**Race**  Amer Ind/AK Native (*specify:*  Amer Ind *and/or*  AK Native)  Asian  Black or African American

Native HI/Pacific Islander (*specify:*  Native HI *and/or*  Pacific Islander)  White  Patient declined to respond  Unk

Additional race information:

Afghan  Afro-Caribbean  Arab  Asian Indian  Bamar/Burman/Burmese  Bangladeshi  Bhutanese

Central American  Cham  Chicano/a or Chicanx  Chinese  Congolese  Cuban  Dominican  Egyptian

Eritrean  Ethiopian  Fijian  Filipino  First Nations  Guamanian or Chamorro  Hmong/Mong

Indigenous-Latino/a or Indigenous-Latinx  Indonesian  Iranian  Iraqi  Japanese  Jordanian  Karen

Kenyan  Khmer/Cambodian  Korean  Kuwaiti  Lao  Lebanese  Malaysian  Marshallese  Mestizo

Mexican/Mexican American  Middle Eastern  Mien  Moroccan  Nepalese  North African  Oromo

Pakistani  Puerto Rican  Romanian/Rumanian  Russian  Samoan  Saudi Arabian  Somali

South African  South American  Syrian  Taiwanese  Thai  Tongan  Ugandan  Ukrainian

Vietnamese  Yemeni  Other: \_\_\_\_\_

What is your (your child's) preferred language? Check one:

Amharic  Arabic  Balochi/Baluchi  Burmese  Cantonese  Chinese (unspecified)  Chamorro  Chuukese

Dari  English  Farsi/Persian  Fijian  Filipino/Pilipino  French  German  Hindi  Hmong  Japanese

Karen  Khmer/Cambodian  Kinyarwanda  Korean  Kosraean  Lao  Mandarin  Marshallese  Mixteco

Nepali  Oromo  Panjabi/Punjabi  Pashto  Portuguese  Romanian/Rumanian  Russian  Samoan

Sign languages  Somali  Spanish/Castilian  Swahili/Kiswahili  Tagalog  Tamil  Telugu  Thai  Tigrinya

Ukrainian  Urdu  Vietnamese  Other language: \_\_\_\_\_  Patient declined to respond  Unknown

Interpreter needed  Yes  No  Unk

**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**

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| <b>Y</b>                 | <b>N</b>                 | <b>Unk</b>               |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Ptosis (drooping eyelids)</b>                  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Cry weak or altered</b>                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Poor feeding</b>                               |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Head drooping</b>                              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Failure to thrive</b>                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Floppy or weak infant</b>                      |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Progressive weakness</b>                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Progressive symmetric descending paralysis</b> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <b>Impaired respiration distress</b>              |

**Predisposing Conditions**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <b>Y</b>                 | <b>N</b>                 | <b>Unk</b>               |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastric surgery or gastrectomy in past |

**Hospitalization**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <b>Y</b>                 | <b>N</b>                 | <b>Unk</b>               |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hospitalized at least overnight for this illness Facility name _____<br>Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____<br>Disposition <input type="checkbox"/> Another acute care hospital <input type="checkbox"/> Died in hospital <input type="checkbox"/> Long term acute care facility<br><input type="checkbox"/> Long term care facility <input type="checkbox"/> Non-healthcare (home) <input type="checkbox"/> Unk<br><input type="checkbox"/> Other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mechanical ventilation or intubation required  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Still hospitalized As of ___/___/___   |
| <b>Y</b>                 | <b>N</b>                 | <b>Unk</b>               |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Died of this illness Death date ___/___/___ <i>Please fill in the death date information on the Person Screen</i>  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Autopsy performed  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Death certificate lists disease as a cause of death or a significant contributing condition<br>Location of death <input type="checkbox"/> Outside of hospital (e.g., home or in transit to the hospital) <input type="checkbox"/> Emergency department (ED)<br><input type="checkbox"/> Inpatient ward <input type="checkbox"/> ICU <input type="checkbox"/> Other _____   |

**Laboratory**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <b>Y</b>                 | <b>N</b>                 | <b>Unk</b>               |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food specimens submitted for testing Describe: |

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

**Travel**

	Setting 1	Setting 2	Setting 3
<b>Travel out of:</b>	<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)
- Breast fed
- Infant formula Brand \_\_\_\_\_
- Commercial baby food
- Honey (e.g., honey-filled pacifier, honey water)
- Corn syrup
- Known contaminated food product Specify \_\_\_\_\_
- Home canned food
- Dried, preserved, or traditionally prepared meat (e.g., sausage, salami, jerky)
- Preserved, smoked, or traditionally prepared fish or marine products
- Contaminated wound during the 2 weeks before onset of symptoms
- Source of botulism identified Specify \_\_\_\_\_

**Exposure and Transmission Summary**

**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  Doctor's office  Hospital ward  Hospital ER  
 Hospital outpatient facility  Place of worship  Laboratory  Homeless/shelter  Social event  
 Large public gathering  Restaurant  Unk  Other \_\_\_\_\_

Describe \_\_\_\_\_

Exposure summary

**Public Health Interventions/Actions**

**Y N Unk**

Letter sent Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Batch date \_\_\_\_/\_\_\_\_/\_\_\_\_

**TREATMENT**

**Y N Unk**

Did patient receive prophylaxis/treatment  
 Specify antitoxin \_\_\_\_\_ Treatment start date \_\_\_\_/\_\_\_\_/\_\_\_\_ Treatment end date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Other medication \_\_\_\_\_

**NOTES**

**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 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 document**Ordering Provider

WDRS ordering provider \_\_\_\_\_

Ordering facility

WDRS ordering facility name \_\_\_\_\_

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