



Campylobacteriosis

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 _____ LHM Case ID (optional) _____
 LHM 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 _____ LHM _____
 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

Clinical Features

Signs and Symptoms

Y N Unk

Diarrhea (3 or more loose stools within a 24 hour period) Onset date ___/___/___
 Bloody diarrhea
 Abdominal pain or cramps
 Nausea
 Vomiting
 Any fever, subjective or measured Temp measured? Yes No Highest measured temp _____°F
 Focal infection

Complications

Y N Unk

Guillain-Barre syndrome
 Bacteremia
 Reactive arthritis

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
 Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
 Still hospitalized As of ___/___/___

Y N Unk

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

RISK AND RESPONSE (Ask about exposures 10 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. _____
 Contact with lab confirmed case
 Household
 Sexual

Y N Unk

Other _____

Attends childcare or preschool Location/details _____

Contact with diapered or incontinent child or adult

Food Exposure - Food exposure timeframe: 1-10 days prior to onset of illness

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

- | | |
|--|---|
| <input type="checkbox"/> (1) Grocery stores or supermarkets | <input type="checkbox"/> (7) Small markets/mini markets (convenience stores, gas stations, etc) |
| <input type="checkbox"/> (2) Home delivery grocery services (CSA, grocery delivery, Amazon Fresh, Peapod, etc) | <input type="checkbox"/> (8) Health food stores or co-ops |
| <input type="checkbox"/> (3) Fish or meat specialty shops (butcher shop, etc) | <input type="checkbox"/> (9) Ethnic specialty markets (Mexican, Asian, Indian) |
| <input type="checkbox"/> (4) Warehouse stores (Costco, Sam's Club, etc.) | <input type="checkbox"/> (10) Farmers markets, roadside stands, open-air markets, food purchased directly from a farm |
| <input type="checkbox"/> (5) Meal delivery services (Blue Apron, Meals on Wheels, Schwan's, NutriSystem, etc) | <input type="checkbox"/> (11) Other _____ |
| <input type="checkbox"/> (6) Live animal market, custom slaughter facility | |

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.) _____

Consumed any of the following during exposure period**Meat****Y M N Unk**

- Poultry (e.g. chicken, turkey)
- Chicken, cooked whole or as cut chicken pieces/parts
Place purchased _____ Type/variety/brand _____
- Ground chicken
Place purchased _____ Type/variety/brand _____
- Breaded chicken products, such as chicken tenders/strips/nuggets _____
- Stuffed, frozen chicken products, such as chicken kiev or chicken cordon bleu _____
- Chicken liver / liver pate _____
- Turkey, cooked whole or as cut turkey pieces/parts _____
- Ground turkey _____
- Other poultry (e.g., duck, game hen, squab) _____

Other processed meat products**Y M N Unk**

Other processed meat products (e.g., jerky, deli meats, sausage)

Miscellaneous meat exposure**Y M N Unk**

- Were any of the previously indicated meats/poultry consumed rare, undercooked, or raw?
 Goat Lamb Beef Pork Poultry Wild game meat Other _____
- Handled any raw meat, even if you did not eat it
 Goat Lamb Beef Pork Poultry Wild game meat Other _____
- Poultry present in the household even if not eaten
- Ground beef present in the household even if not eaten

Eggs and Dairy**Y M N Unk**

- Raw/unpasteurized milk (including cow, goat, sheep, etc.)
Dairy animal type Cow Goat Sheep Other _____
Type, variety or brand _____
- Any raw/unpasteurized milk left over
- Cheese made from raw/unpasteurized milk including homemade, farm-fresh, and door-to-door cheeses
Type, variety or brand _____
- Any raw/unpasteurized cheese left over
- Other raw/unpasteurized dairy product (e.g., yogurt, kefir, ice cream)
Type, variety or brand _____
- Any raw/unpasteurized dairy product left over

Water Exposure**Y N Unk****Describe**

- Source of drinking water known
- Bottled water _____
- Public water system _____
- Individual well _____
- Shared well _____
- Other _____
- Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring) _____
- Any recreational water exposure (e.g., lake, river, pool, waterpark) _____
Water site name/location _____
Treatment Treated Untreated Unk
Type Lake River Pool/hot tub Wading pool Fountain Waterpark
 Splash pad/water playground Other

Animal Exposure**Y N Unk**

Any contact with pet animals at home or elsewhere

Y N Unk

- Cats or kittens
- Dogs or puppies
- Pet birds such as parakeets, parrots, cockatiels _____
- Any sick pets _____
- Any new household pets in the last month _____

Y N Unk

- Any contact with pet food or treats
- Raw pet food Type/variety/brand _____
- Pet treats or chews (pig ears, pizzles, rawhide, hooves, etc.) Type/variety/brand _____
- Prepackaged pet food (canned or dry) Type/variety/brand _____

Y N Unk

- Any contact with farm animals, including chickens or ducks
- Cows or calves
- Baby chicks, ducklings or baby poultry _____
- Adult chickens, turkeys, or other adult poultry _____
- Other animal contact _____

Animal Settings

Y N Unk

- Live on a farm or other setting that has farm animals _____
- Household member works with animals _____
- Work with animals or animal products (e.g., research, farming, veterinary medicine, animal slaughter)

Exposure to any of the following facilities/settings even if no direct animal contact

	Y N Unk	Describe	Type of exposure
Research facility	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Slaughterhouse	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Veterinary facility	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit

Visited or worked on any of the following settings even if no direct animal contact

	Y N Unk	Location, animals, etc.	Type of exposure
Petting zoo	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Zoo	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Dairy farm	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Other farm contact	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Agricultural 'Farm and Feed' store	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
County/state fairs, 4-H events, or similar events where animals are present	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Pet store or other places where animals are sold or adopted	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Attended any school events, birthday parties, or similar events with animals/pets	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit
Other setting with animals Describe _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> Work <input type="checkbox"/> Visit

Exposure and Transmission Summary

Y N Unk

- Epi-linked to a confirmed or probable case**
- Outbreak related**
- 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 Waterborne Animal related 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 International travel Out of state travel Transit
 Social event Large public gathering Restaurant Hotel/motel/hostel Other _____

Describe _____

Exposure summary

- Suspected transmission type (check all that apply) Foodborne Waterborne Animal related Unk
 Other _____

Describe _____

- Suspected transmission setting (check all that apply) 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
 International travel Out of state travel Transit Social event Large public gathering Restaurant
 Hotel/motel/hostel Other _____

Describe _____

Public Health Issues

Y N Unk

- Household member or close contact in sensitive occupation or setting (HCW, childcare, food)
 Does patient have contact with a day care
 Non-occupational food handling (e.g., potlucks, receptions) during contagious period
 Employed as a food handler
 Employed as a health care worker
 Employed in childcare or preschool

If needed, enter detailed information in the Transmission Tracking Question Package

Public Health Interventions/Actions

Y N Unk

- Exclude case from sensitive occupations (HCW, food, childcare) or situations (childcare) until diarrhea ceases
 Hygiene education provided
 Childcare inspection
 Investigation of raw milk dairy
 Work or childcare restriction for household member
 Restaurant inspection Restaurant name/location _____
 Commercial product implicated
 Initiate trace-back investigation
 Letter sent Date ___/___/___ Batch date ___/___/___
 Any other public health action _____

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious Yes No Unk

Settings and details (check all that apply)

- Daycare School Airport Hotel/Motel/Hostel Transit Healthcare Home Work College
 Military Correctional facility Place of worship International travel Out of state travel LTCF
 Homeless/shelter Social event Large public gathering Restaurant Other

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type (as checked above)				
Facility Name				
Start Date	___/___/___	___/___/___	___/___/___	___/___/___
End Date	___/___/___	___/___/___	___/___/___	___/___/___
Time of Arrival				
Time of Departure				
Number of people potentially exposed				
Details (hotel room #, HC type, transit info, etc.)				
Contact information available for setting (who will manage exposures or disease control for setting)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk
Is a list of contacts known?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk

If list of contacts is known, please fill out contact tracing form Question Package

TREATMENT**Y N Unk** Did patient receive prophylaxis/treatment

Specify antibiotic _____

Treatment start date ___/___/___ Treatment end date ___/___/___ Number of days actually taken _____

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 documentOrdering Provider

WDRS ordering provider _____

Ordering facility

WDRS ordering facility name _____