



Shigellosis

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

Clinical Features

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

Predisposing Conditions

Y N Unk
 Immunosuppressive therapy or condition, or disease Specify _____
 Other underlying medical condition Specify _____

Hospitalization

Y N Unk

Hospitalized at least overnight for this illness Facility name _____
 Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____

Y N Unk

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 1-7 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. _____

- Contact with lab confirmed case
- Childcare/Day care
- Household
- Sexual
- Occupational
- Other _____
- Attends child-care or preschool Location/details _____
- Contact with diapered or incontinent child or adult

Food Exposure - Food exposure timeframe: 1-7 days prior to onset of illness

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:

- (1) Fast casual (Chipolte, Panera, etc)
- (2) Fast food (McDonald's, Burger King, Wendy's)
- (3) Sandwich shop, deli
- (10) Chinese, Japanese, Vietnamese, other Asian-style
- (11) All-you-can-eat buffet
- (12) Breakfast, brunch, diner, or café

- (4) Jamaican, Cuban, or Caribbean
- (5) Ready-to-eat prepared food from grocery or deli
- (6) An event where food was served (catered event, festival, church, or community meal)
- (7) Mexican, Salvadorian, other Hispanic/Latino-style
- (8) Food trucks, food stalls/stands
- (9) School, hospital, senior center, or other institutional setting
- (13) Middle Eastern, Greek/Mediterranean, Arabic, Lebanese, African
- (14) Any takeout from a restaurant
- (15) Healthy restaurant (vegetarian, vegan, salad-based)
- (16) Salad bar at a grocery store or restaurant
- (17) Other _____

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.) _____

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

Sexual Exposure

Y N Unk

Any type of sexual contact with others during the exposure period

Number of sexual partners during exposure period _____ Female _____ Male

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 Person to person Sexual Health care associated Unk

Other _____

Describe _____

- Suspected exposure setting Daycare/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 Person to person Sexual
 Health care associated Unk Other _____

Describe _____

- Suspected transmission setting (check all that apply) Daycare/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)
 Follow-up of household members
 Non-occupational food handling (e.g., potlucks, receptions) during contagious period
 Employed as a food handler
 Employed as a health care worker
 Employed in or resident of long-term care facility
 Employed in childcare or preschool
 Attends childcare or preschool

Public Health Interventions/Actions

Y N Unk

- Exclude individuals in sensitive occupations or settings (HCW, food, childcare) until 2 negative stools
Case cleared 2 negative labs Health officer approved Other _____
 Hygiene education provided
 Childcare inspection
 Restaurant inspection Restaurant name/location _____
 Work or childcare restriction for household member
 Commercial product implicated
 Water supply implicated
 Testing of home/other water supply
 Letter sent Date ___/___/___ Batch date ___/___/___
 Any other public health action _____

TREATMENT

Y N Unk

- Did patient receive prophylaxis/treatment
Specify medication _____
Number of days actually taken _____

NOTES

LAB RESULTS

Lab report information _____ Submitter _____
Lab report reviewed – LHJ Performing lab for entire report _____
WDRS user-entered lab report note 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 Pending

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

Ordering facility

WDRS ordering provider _____

WDRS ordering facility name _____