



Typhoid fever

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

Signs and Symptoms

Y N Unk
 Any fever, subjective or measured If yes, Temp measured? Yes No Highest measured temp _____ °F
 Constipation
 Abdominal pain or cramps
 Anorexia (loss of appetite)
 Night sweats
 Headache
 Malaise
 Cough Onset date ___/___/___
 Nonproductive cough
 Diarrhea (3 or more loose stools within a 24 hour period) Onset date ___/___/___
 Fatigue

Clinical Findings

Y N Unk

- Rash-rose spots**
 - Relative bradycardia (*heart rate that, although not actually below 60 BPM, is still considered too slow for the individual's current medical condition*)
 - Splenomegaly
- Outcome of illness Recovered Died Unk Other _____

Predisposing Conditions

Y N Unk

- Previously known typhoid carrier
- Immunosuppressive therapy or condition, or disease _____
- Other underlying medical condition _____

Vaccination

Y N Unk

- Typhoid vaccine within 5 years before illness onset

Vaccine information available Yes No

Date of vaccine administration ___/___/___ Vaccine administered (Type) _____

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 ___/___/___
- Mechanical ventilation or intubation required
- Still hospitalized As of ___/___/___

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

RISK AND RESPONSE (Ask about exposures 3-60 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 ___/___/___

If international travel, Purpose of travel:

Y N Unk

- Business
- Tourism
- Visiting relatives or friends
- Immigration to U.S.
- Other _____

Risk and Exposure Information

Y N Unk

- Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country _____
- Contact with lab confirmed case
 - Childcare/Day care
 - Household
 - Sexual
 - Needle use
 - Other _____
- Contact with known Typhoid carrier Date(s) of contact ___/___/___
- Was the carrier previously known to the health department
 - Day care
 - Household
 - Sexual
 - Needle use
 - Other _____
- Contact with recent foreign arrival Country _____ Date(s) of contact ___/___/___

- Day care
- Household
- Sexual
- Needle use
- Other _____
- Does the case know anyone else with similar symptoms or illness
Onset date, shared meals, relationship, etc. _____
- Attends child-care or preschool Location/details _____
- Contact with diapered or incontinent child or adult

Food Exposure - Food exposure timeframe: 3-60 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
- (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
- (10) Chinese, Japanese, Vietnamese, other Asian-style
- (11) All-you-can-eat buffet
- (12) Breakfast, brunch, diner, or café
- (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.) _____

Y M N Unk

Refrigerated, prepared food (e.g., dips, salsas, salads, sandwiches)

Water Exposure

Y N Unk

Describe

Source of drinking water known
 Bottled water _____

Y N Unk

Public water system _____
 Individual well _____
 Shared well _____
 Other _____
 Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring) _____

Exposure and Transmission Summary

Y N Unk

Epi-linked to a confirmed case
 Known contaminated food product Specify _____
 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 Blood products IDU Unk
 Other _____

Describe _____

Exposure summary

Public Health Issues

Y N Unk

Employed as a food handler
 Non-occupational food handling (e.g., potlucks, receptions) during contagious period
 Employed in childcare or preschool
 Attends childcare or preschool
 Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis Date ___/___/___
 Agency/location _____ Type of donation _____

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

Public Health Interventions/Actions

Y N Unk

Exclude individuals in a sensitive occupation (HCW, childcare) or situation (childcare) until 3 negative stools
 Case cleared 3 negative labs Health Officer approved Other _____
 Consider excluding symptomatic contacts from sensitive occupations (HCW, food, childcare) or situations (childcare) until 2 negative stools
 Clearance testing done without exclusion
 Case cleared 3 negative labs Health Officer approved Other _____
 If no, reason why not _____
 Notify others sharing exposure
 Notified blood or tissue bank (if recent donation)
 Hygiene education provided
 Childcare inspection
 Follow-up of household members
 Work or childcare restriction for household member
 Letter sent Date ___/___/___ Batch date ___/___/___
 Any other public health action _____

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

Settings and details (check all that apply)

- Day care School Airport Hotel/Motel/Hostel Transit Health care 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				
	Setting 1	Setting 2	Setting 3	Setting 4
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 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 _____