



# Typhoid fever

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

**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:

- |  |   |
|--|---|
| <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.) \_\_\_\_\_

**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 \_\_\_\_\_
- Y N Unk**
- 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 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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