



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 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 _____

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