Botulism, Other

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
Toxin type ______

Clinical Features

Y	N	Unk	
☐	☐	☐	**Bulbar weakness (cranial nerve abnormalities)**
☐	☐	☐	**Blurred vision**
☐	☐	☐	**Diplopia (double vision)**
☐	☐	☐	**Ptosis (drooping eyelids)**
☐	☐	☐	**Swallowing or speech difficulty**
☐	☐	☐	Dyspnea (shortness of breath)
☐	☐	☐	**Progressive symmetric descending paralysis**
☐	☐	☐	**Respiratory distress**
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea (*3 or more loose stools within a 24 hour period)*
☐	☐	☐	Abscess, infected lesion, wound or break in skin

Predisposing Conditions

Y N Unk

☐ ☐ ☐ Gastric surgery or gastrectomy in past

Hospitalization

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name ___________________________________

Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____________________

Disposition ☐ Another acute care hospital ☐ Died in hospital ☐ Long term acute care facility ☐ Long term care facility ☐ Non-healthcare (home) ☐ Unk ☐ Other ___________________________________

☐ ☐ ☐ 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

Location of death ☐ Outside of hospital (e.g., home or in transit to the hospital) ☐ Emergency department (ED) ☐ Inpatient ward ☐ ICU ☐ Other ___________________________________

RISK AND RESPONSE (Ask about exposures 12 hours - 7 days before symptom onset)

Travel

	Setting 1	Setting 2	Setting 3
Travel out of:	☐ County/City ______________ ☐ State ______________ ☐ Country ______________ ☐ Other ______________	☐ County/City ______________ ☐ State ______________ ☐ Country ______________ ☐ Other ______________	☐ County/City ______________ ☐ State ______________ ☐ Country ______________ ☐ 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. ___________________________________

☐ ☐ ☐ High-risk food exposure (e.g., home-canned, vacuum-packed, preserved meat or fish, food in oil)

☐ ☐ ☐ Injected drugs not prescribed by a doctor, even if only once or a few times Describe ____________________________

☐ ☐ ☐ Non-injection street drug use

☐ ☐ ☐ Contaminated wound during the 2 weeks before onset of symptoms

☐ ☐ ☐ Source of botulism exposure suspected

☐ ☐ ☐ Food ___________________________________

☐ ☐ ☐ Inhalation

☐ ☐ ☐ Wound

Food Exposure - ***Food exposure timeframe: 12 hours to 7 days prior to onset of illness. Only ask about detailed food exposures if no risk exposure is identified, but Foodborne Botulism is suspected***

Sources of food

	Name, location, dates shopped	Name, location, dates shopped
Ethnic specialty markets		
Farmer's markets or purchases at a farm		
Grocery store or supermarket		
Health food; Co-op; Fish or meat specialty shop		
School or institution		
Small or mini market, convenience store		
Warehouse store		
Other		
Other		

Y M N Unk
☐ ☐ ☐ ☐ During food exposure timeframe, did you eat food outside the home (including take-out)
☐ ☐ ☐ ☐ Restaurant (type: Asian; BBQ/Steak/Grill; Breakfast/Brunch/Diner; Chinese; Fast food; French; Indian; Italian; Jamaican/Cuban/Caribbean; Mexican; Middle Eastern/Arabic/Lebanese; Seafood; Sushi; Vegetarian/Vegan; Other)

Name, location	**Date and time** (mm/dd/yyyy ##:## AM/PM)	**Foods eaten**	**Type** (see list above)

Y M N Unk **Details**
☐ ☐ ☐ ☐ Group meal (e.g., potluck, reception) ______________________________

Exposure and Transmission Summary
Y N Unk
☐ ☐ ☐ **Epidemiologic link (e.g., ingestion of home-canned food within the previous 48 hours)**
☐ ☐ ☐ **Ingestion of the same food as persons who have laboratory-confirmed botulism**

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 ☐ 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 ☐ Social event ☐ Large public gathering ☐ Restaurant ☐ Hotel/motel/hostel ☐ Other ______________________________
Describe ______________________________
Exposure summary

Public Health Interventions/Actions
Y N Unk
☐ ☐ ☐ Notify others potentially exposed Date initiated ___/___/___
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Any other public health action ______________________________

TREATMENT

Y N Unk
☐ ☐ ☐ Did patient receive prophylaxis/treatment
Specify antitoxin ____________________ Treatment start date ___/___/___ Treatment end date ___/___/___
Other 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 ☐ 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
WDRS ordering provider ________________________________

Ordering facility
WDRS ordering facility name ________________________________