



Botulism, Other

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 _____ LHJ Case ID (optional) _____
 LHJ 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 _____ LHJ _____
 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

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:	<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. _____
- 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

- Group meal (e.g., potluck, reception) _____

Details

Exposure and Transmission Summary**Y N Unk** **Epidemiologic link (e.g., ingestion of home-canned food within the previous 48 hours)****Y N Unk** **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 _____ UnkInternational 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 _____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.