Washington State Department of Health

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 childs) 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

Case Name _____ LHJ Case ID _____

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 _____

Case Name _____ LHJ Case ID _____

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) _____

Case Name _____ LHJ Case ID _____

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 _____ ☐ 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 _____