

Botulism

COUNTY

for state use only

#

Foodborne Intestinal: Infant Intestinal: adult Wound _____

Date investigation initiated: ___/___/___ Time ___:___ am pm

___/___/___ case report

confirmed

presumptive

___/___/___ interstate

suspect

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

e-mail address _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____

indicate home (H); work (W); message (M)

Address _____

Street

City

Zip

SOURCES OF REPORT (check all that apply)

Lab Infection Control Practitioner

Physician _____

Name _____

Phone _____

Date ___/___/___ Time ___:___
(first report)

Primary M.D. _____
(if different)

OK to talk to patient?

Phone _____

DEMOGRAPHICS

SEX female male

HISPANIC yes no unknown

RACE

White American Indian

Black Asian/Pacific Islander

unknown refused to answer

other _____

DATE OF BIRTH ___/___/___
m d y

or, if unknown, AGE _____

Worksites/school/day care center _____

Occupations/grade _____

BASIS OF DIAGNOSIS

EPI-LINKAGE

During the exposure period, was the patient...

associated with a known outbreak? yes no unk

a close contact of a **confirmed** or **presumptive** case? yes no unk

Has the above case been reported? yes not yet

Specify nature of contact:

household meal companion _____

if yes to any question, specify relevant names, dates, places, etc:

CLINICAL DATA

Type of botulism

Foodborne Intestinal: Infant Intestinal: adult Wound

Date of first symptoms ___/___/___
m d y

Hospitalized: yes no unk

name of hospital _____

date of admission ___/___/___

date of discharge ___/___/___

Transferred to/from another hospital:

yes no unk to: _____

Outcome: survived died unk

date of death ___/___/___

Recent medication history:

phenothiazine yes no comment _____

aminoglycoside yes no comment _____

anticholinergic yes no comment _____

other _____ comment _____

abdominal pain yes no unk

nausea yes no unk

vomiting yes no unk

diarrhea yes no unk

blurred vision yes no unk

diplopia yes no unk

dizziness yes no unk

slurred speech yes no unk

sensation of "thick tongue" yes no unk

change in sound of voice yes no unk

hoarseness yes no unk

dry mouth yes no unk

difficulty swallowing yes no unk

shortness of breath yes no unk

subjective weakness yes no unk

fatigue yes no unk

paresthesia yes no unk

if yes, describe _____



BASIS OF DIAGNOSIS (continued)

Signs:

vital signs: temp _____ BP _____/_____ HR _____/min RR _____/min

altered mental state yes no unk

extrocular palsy yes no unk bilateral

ptosis yes no unk bilateral

pupils: dilated yes no unk bilateral

constricted yes no unk bilateral

fixed yes no unk bilateral

reactive yes no unk bilateral

facial paralysis yes no unk bilateral

palatal weakness yes no unk bilateral

impaired gag reflex yes no unk bilateral

wound yes no unk

if yes, describe _____

sensory deficits yes no unk

if yes, describe _____

abnormal DTRs yes no unk

if yes, describe _____

weakness/paralysis:

Indicate if weakness or paralysis was noted before antitoxin release:

Extremities:

upper distal yes no unk bilateral

upper proximal yes no unk bilateral

lower distal yes no unk bilateral

lower proximal yes no unk bilateral

Describe progression of the weakness/paralysis:

ascending

descending

unknown

Morbidity:

List morbidity present before antitoxin release:

admitted to intensive care: yes no unk

ventilator: yes no unk

tracheostomy: yes no unk

other: yes no unk

Describe general symptom progression if not already covered:

Physician's differential diagnosis:

- 1.
- 2.
- 3.

Notes on Botulism Antitoxin

Physician contact _____ phone _____

Pharmacist contact _____ phone _____

Hospital _____

Antitoxin released? yes no

Antitoxin administered? yes no

if yes, date / / time _____
m d y

OHD epidemiologist _____

CDC contact _____ phone _____

Details of antitoxin shipping:



CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER

name	age	occupation	neurologic symptoms			onset	education provided			comments
			yes	no	unk		yes	no	unk	
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does the case know about anyone else with a similar illness? yes no could not be interviewed
 if yes, give names, onset dates, contact information, and other details.

SUMMARY OF FOLLOW-UP AND COMMENTS. Provide details as appropriate.

- referral to physician
- follow up of others who ate suspect food
- referral of suspect food to regulatory agency
- restaurant inspection
- education on proper canning technique provided
- _____

ADMINISTRATION

Date and time case report sent to OHS: ___/___/___ ___ am pm

Completed by _____ Date _____ Phone _____ Investigation sent to OHS on ___/___/___

Remember to copy patient's name to the top of this page.