

Campylobacteriosis

PATIENT DEMOGRAPHICS

Name (last, first): _____		*Birth date: __/__/____ Age: _____
Address (mailing): _____		*Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk
Address (physical): _____		*Ethnicity: <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unk
City/State/Zip: _____		*Race: <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. (Mark all that apply) <input type="checkbox"/> Native HI/Other PI <input type="checkbox"/> Am. Ind/AK Native <input type="checkbox"/> Asian <input type="checkbox"/> Unk
Phone (home): _____ Phone (work/cell): _____		
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other Name: _____ Phone: _____		

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): _____	Case Classification: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown
Investigation Start Date: __/__/____	
Earliest date reported to LHD: __/__/____	
Date sent for Regional Review: __/__/____	

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: Laboratory Hospital Private Provider Public Health Agency Other

Reporter Name: _____ Reporter Phone: _____

Primary HCP Name: _____ Primary HCP Phone: _____

CLINICAL

Onset date: __/__/____	Diagnosis date: __/__/____	Recovery date: __/__/____
Clinical Findings Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloody stool <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever highest temp _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Abdominal cramps Complications <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Guillian-Barre Syndrome <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Reactive arthritis		*Hospitalization Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospitalized for this illness Hospital name: _____ Admit date: __/__/____ Discharge date: __/__/____ *Death Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Died due to this illness Date of death: __/__/____

LABORATORY (Please submit copies of all labs associated with this illness to DIDE)

Specimen source: <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	Y N U
Collection date: __/__/____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Campylobacter detected by polymerase chain reaction (PCR) test, such as film array
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Campylobacter antigen by immunodiagnostic test such as EIA
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Culture positive for Campylobacter
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Isolate submitted to state public health lab (OLS)

Notes (clinical/laboratory)

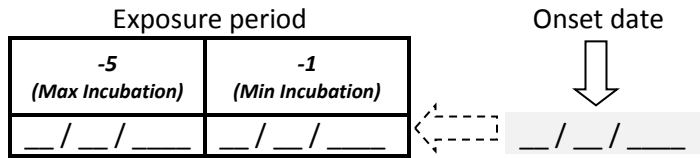
INFECTION TIMELINE

Instructions:

Enter onset date in grey box. Count backward to determine probable exposure period

Days from onset

Calendar dates:



EPIDEMIOLOGIC (Unless otherwise stated, questions refer to the exposure period calculated above.)

- | | |
|--|---|
| <p>Y N U</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> * Eat raw or undercooked chicken, turkey or other poultry?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> * Eat or drink raw or unpasteurized milk?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> * Eat unpasteurized dairy products (soft cheese from raw milk, queso fresco, etc.)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eat raw or undercooked hamburger, red meat, or pork?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Drink untreated/unchlorinated water (i.e. surface, well)?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Contact with poultry (domestic or wild)?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel to another state or country? If yes, where _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hike, camp, fish or swim? If yes, where _____</p> | <p>*Is case a member of a high risk occupation?
(Mark one)</p> <p><input type="checkbox"/> Food Handler</p> <p><input type="checkbox"/> Health Care Worker</p> <p><input type="checkbox"/> Day Care Worker/Attendee</p> <p><input type="checkbox"/> Student</p> <p><input type="checkbox"/> None of Above</p> <p>Employer/School Name: _____</p> |
|--|---|

Attend any group activities, parties or gatherings? **Yes / No** If yes, list

Date	Activity	Location

Eat at any restaurant in the last 7 days? **Yes / No** If yes, list

Date	Name of Restaurant	Location

Complete Open-Ended Food History on next page.

Information does not need entered into WVEDSS, however it should be kept with the paper record of the case. State health department staff may request if case is later identified as part of an outbreak.

Food History Completed? Yes / No

PUBLIC HEALTH ISSUES

If any household member is symptomatic, the member is epi-linked and therefore is a probable case and should be investigated further. A stool culture and disease case report should be completed.

Name	Relationship to Case	Onset Date	Lab Testing

- Y N NA**
- Employed as food handler
- Non-occupational food handling (e.g. pot lucks, receptions)
- Attends or employed in child care
- Household member or close contact in sensitive occupation (food, HCW, child care)
- Case is part of outbreak
- Outbreak Name: _____

PUBLIC HEALTH ACTIONS

- Y N NA**
- Disease/Transmission Education Provided
- Exclude individuals in sensitive occupations(food, HCW, child care)
- Restaurant inspection
- Child care inspection
- Culture symptomatic contacts
- Patient is lost to follow up
- Other: _____

Name: _____
 DOB: _____
 Condition: Campylobacteriosis

OPEN ENDED FOOD HISTORY

(for Enteric Diseases)

DAY 1 (DATE OF ONSET)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		

DAY 2 (1 day before onset)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		

DAY 3 (2 days before onset)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		

DAY 4 (3 days before onset)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		

DAY 5 (4 days before onset)

Date:	Food/Beverage Consumed	Location Where Consumed/Purchased
Breakfast		
Lunch		
Dinner		
Snacks/Other		

