

# Botulism, Infant

## PATIENT DEMOGRAPHICS

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

## INVESTIGATION SUMMARY

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

<b>Onset date:</b> __/__/____ <b>Diagnosis date:</b> __/__/____ <b>Recovery date:</b> __/__/____	
<b>Clinical Findings</b> Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor feeding <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Floppy or weak baby <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Head drooping <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eyelids drooping (ptosis) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cry weak or altered <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Breathing difficulty or shortness of breath <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failure to thrive <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sepsis syndrome <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Altered mental status <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mechanical ventilation or intubation required <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Paralysis or weakness <input type="checkbox"/> Acute flaccid paralysis <input type="checkbox"/> Asymmetric <input type="checkbox"/> Symmetric <input type="checkbox"/> Ascending <input type="checkbox"/> Descending	<b>*Hospitalization</b> Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hospitalized for this illness Hospital name: _____ Admit date: __/__/____ Discharge date: __/__/____  <b>*Death</b> Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Died due to this illness Date of death: __/__/____
<b>TREATMENT</b> Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> *Botulinum antitoxin given Date/time given: __/__/____ _____ AM/PM	

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

**Specimen source:**  Serum  Stool **Collection date:** \_\_/\_\_/\_\_\_\_  
 Y N U  
   Botulinum toxin detection (serum or stool) **Toxin type:**  A  B  C  D  E  F  G  Unknown  
   C. botulinum isolation (stool)  
   Food specimen submitted for testing

## Notes(clinical/laboratory)

## INFECTION TIMELINE

**Instructions:**

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

	Exposure period		Onset date
<b>Days from onset</b>	-30 <i>(Max Incubation)</i>	-3 <i>(Min Incubation)</i>	↓
<b>Calendar dates:</b>	_ / _ / _	_ / _ / _	_ / _ / _

## EPIDEMIOLOGIC EXPOSURES

Y N U

- \*Honey (e.g. honey-filled pacifier, honey water)
- Corn syrup
- If infant, breast fed
- Infant formula Brand and Type: \_\_\_\_\_
- Commercial baby food Brand: \_\_\_\_\_
- Home canned food
- Dried, preserved, or traditionally prepared meat (e.g. sausage, jerky, salami)
- Preserved, smoked, or traditionally prepared fish
- Known contaminated food product Specify: \_\_\_\_\_
- Travel out of the state, country or outside of usual routine

If yes, dates/locations:

Date	Location

## PUBLIC HEALTH ISSUES

Y N NA

- Antitoxin needed
- Commercial product possibly implicated
- Case is part of an outbreak  
Outbreak Name: \_\_\_\_\_

## PUBLIC HEALTH ACTIONS

Y N NA

- Disease/Transmission Education Provided
- Contacted state to arrange for antitoxin
- Patient is lost to follow up
- Other: \_\_\_\_\_

## NOTES