

# Salmonellosis

## 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.
Phone (home): _____ Phone (work/cell) : _____		(Mark all that apply) <input type="checkbox"/> Native HI/Other PI
Alternate contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other		<input type="checkbox"/> Am. Ind/AK Native
Name: _____ Phone: _____		<input type="checkbox"/> Asian <input type="checkbox"/> Unk

## 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: __/__/____
<b>Clinical Findings</b> 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		<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: __/__/____

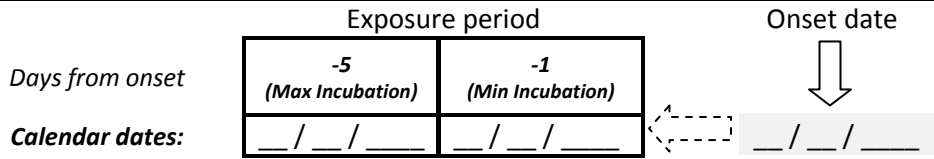
## LABORATORY (Please submit copies of all labs, including sensitivities, associated with this illness to DIDE)

Specimen source: <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Other _____	*Antibiotic Susceptibility Testing: Enter results for the following medications in the Laboratory Event associated with this investigation Ampicillin Ciprofloxacin Trimethoprim/Sulfamethoxazole
Collection date: __/__/____	
Y N U <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Culture positive for Salmonella species <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



**EPIDEMIOLOGIC EXPOSURES** (Unless stated otherwise, the questions pertain to the exposure period calculated above.)

- Y N U**
- \*Eat fresh shell eggs?
  - \*Eat raw eggs (Egg nog, sauces, cookie dough, cake batter, etc.)?
  - \*Eat raw or undercooked chicken, turkey or other fowl?
  - Eat raw or undercooked hamburger, red meat, or pork?
  - Eat or drink raw or unpasteurized milk?
  - \*Eat raw fruits or vegetables?
  - \*Contact with birds, poultry, farm animals or reptiles? Where \_\_\_\_\_
  - Travel to another state or country? If yes, where \_\_\_\_\_
  - Hike, camp, fish or swim? If yes, where \_\_\_\_\_
- \*Is case a member of a high risk occupation?**  
(Mark one)
- Food Handler
  - Health Care Worker
  - Day Care Worker/Attendee
  - Student
  - None of Above
- Employer/School Name: \_\_\_\_\_

Name and location of store where typically buys groceries \_\_\_\_\_

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 an 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: Salmonellosis

# 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		