Botulism

Agency: ____

Investigator: ____ Phone number: ____

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: ____
First and middle name: ____
Maiden name: ____ Suffix: ____
Address line: ____
Zip: ____ City: ____
State: ____ County: ____
Phone: ( )- - Type: ____
Long-term care resident: ☐ Yes ☐ No ☐ Unknown
Facility name: ____

Date of Birth: / / Estimated? ☐ Age: ____
Gender: ☐ Female ☐ Male ☐ Other ____
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name: ____
Parent/Guardian phone: ( )- - Type: ____

EVENT

Disease type Foodborne ☐ Wound ☐ Infant ☐ Adult intestinal toxemia ☐

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Date of death / /
Event exception ☐ Case could not be found ☐ Case could not be interviewed ☐ Case refused interview ☐ Other – see notes
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name: ____
Exposure setting: ____
Epi-linked: ☐ Yes ☐ No ☐ Unknown
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: ____ Country: ____

Healthcare provider information

Last name: ____
First name: ____
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name: ____
Address line 1: ____
Address line 2: ____
Zip code: ____ City: ____
State: ____ County: ____
Phone : ( )- - Type: ____

LABORATORY FINDINGS

Laboratory: ____ Accession #: ____ Collection date: / /
Date received: / / Specimen source: ____ Test type: ____
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Toxin Type: ☐ A ☐ B ☐ Other ____

Laboratory: ____ Accession #: ____ Collection date: / /
Date received: / / Specimen source: ____ Test type: ____
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Toxin Type: ☐ A ☐ E ☐ B ☐ F ☐ Other ____

Laboratory: ____________ Accession #: ____________ Collection date: ___/___/______

Date received: ___/___/______ Specimen source: ____________ Test type: ____________

Result type: ☐ Preliminary ☐ Final Result date: ___/___/______ Result: ☐ Positive ☐ Negative ☐ Other ________

Organism: Toxin Type: ☐ A ☐ B ☐ E ☐ F

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: ____________ Job title: ____________

: ☐ Yes ☐ No ☐ Unknown Facility name: ____________

Date worked from: ___/___/______ Address: ____________

Date worked to: ___/___/______ Zip code: ____________

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ____________ State: ______ County: ____________

Date removed: ___/___/______ Phone: (   )-   - Type:

Occupation type: ____________ Job title: ____________

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: ____________

Date worked from: ___/___/______ Address: ____________

Date worked to: ___/___/______ Zip code: ____________

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: ____________ State: ______ County: ____________

Date removed: ___/___/______ Phone: (   )-   - Type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: ____________ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): ____________

Admission date: ___/___/______ Discharge date: ___/___/______ Days hospitalized: ____________

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Symptoms:

☐ Abdominal cramps
☐ Blurred vision
☐ Constipation
☐ Diarrhea
☐ Diplopia (double vision)
☐ Dizziness
☐ Dry Mouth
☐ Erythema
☐ Fever
☐ Slurred Speech
☐ Vomiting

Preexisting wound 14 days prior to onset? ☐ Yes ☐ No ☐ Unk

Wound location:
☐ Head
☐ Trunk
☐ Upper extremity
☐ Lower extremity

Wound type:
☐ Abrasion
☐ Avulsion
☐ Burn
☐ Compound fracture
☐ Crush
☐ Frostbite
☐ Linear laceration
☐ Puncture
☐ Stellate laceration

Wound depth: ☐ 1 cm or less ☐ >1 cm

Signs of infection: ☐ Yes ☐ No ☐ Unk

Contaminated: ☐ Yes ☐ No ☐ Unknown

Devitalized, ischemic, or denervated tissue: ☐ Yes ☐ No ☐ Unknown

Date wound occurred: ___/___/______

Setting:
☐ Automobile
☐ Farm/yard
☐ Home
☐ Petting Zoo
☐ Work
☐ Other ____________

Other wound details: ________________________________

____

Botox injections 14 days prior to symptoms? ☐ Yes ☐ No ☐ Unknown

(If Yes, complete the following section. If No, skip to the next section.)

Injection date: / / Facility name: Provider name:

Address: City: State: Zip:

County: Phone: ( )- - Type:

Tensilon test performed: ☐ Yes ☐ No ☐ Unk Date: / / **Results:** ☐ Positive ☐ Negative ☐ Equivocal ☐ Unknown

EMG test performed: ☐ Yes ☐ No ☐ Unk Date: / / **Compatible with Botulism diagnosis?** ☐ Yes ☐ No ☐ Unk

OTHER LAB FINDINGS

Food, medication or environmental samples tested? ☐ Yes ☐ No ☐ Unknown

(If Yes, complete the following section. If No, then skip to the next section.)

Tested for preformed toxin: ☐ Yes ☐ No ☐ Unk Laboratory: ______________ Toxin type: ☐ A ☐ B ☐ E ☐ F ☐ G

Describe samples: ______________ List positive samples: ______________

Tested for C. botulinum or other serotype: ☐ Yes ☐ No ☐ Unk Laboratory: ______________

Describe samples: ______________ List positive samples: ______________

TREATMENT

For the illness, were any of the following treatments required:

Tracheotomy: ☐ Yes ☐ No ☐ Unk **Ventilator:** ☐ Yes ☐ No ☐ Unk Duration in days: ______________

Antitoxins prescribed? ☐ Yes ☐ No ☐ Unk **Therapeutic medications prescribed?** ☐ Yes ☐ No ☐ Unk

Date started: ______________ List medications: ______________

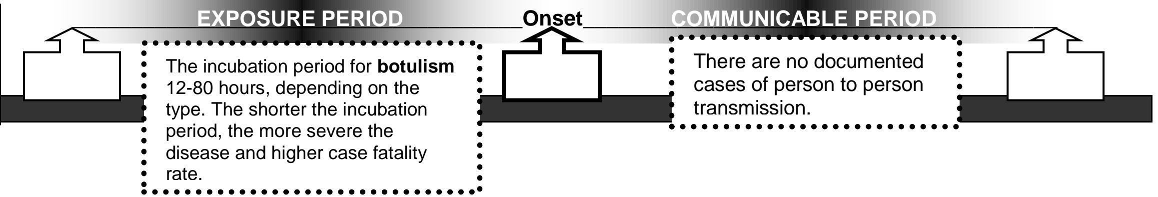
Dose: ________ Unit: ________

days: ________ # times each day: ________

Route: ______________

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



In the 36 hours prior to onset of symptoms did the case consume:

Home canned foods: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types:

Fish: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Meat other than fish: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Potato or potato products: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: ______________ List all brand names: ______________

Describe preparation:

Other root vegetable: ☐ Yes ☐ No ☐ Unk From dates consumed: ___/___/___ To dates consumed: ___/___/___

List all source/types: List all brand names:

In the 14 days prior to symptoms did the case Inject street drugs or steroids? ☐ Yes ☐ No ☐ Unknown

CONTACTS

Contacts with the same exposures ☐ Yes ☐ No ☐ Unknown

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same foods consumed?	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same foods consumed?	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same foods consumed?	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Yes ☐ No	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same foods consumed?	Is contact a case?
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If this contact is a case create a new event and/or case for this contact.

NOTES: