Campylobacter

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 name:

Middle name:

Address line:

Zip: City:

State: County:

Phone: ( )- - Type:

Parent/guardian 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 ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ Asian

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Parent/guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown

Reason for testing:

Aware of diagnosis: ☐ Yes ☐ No

Speak English: ☐ Yes ☐ No If no, what lang:

Public Health Investigation Initiation

Date PH consulted healthcare provider: / /

Date PH first attempted to contact patient: / /

Was patient educated on disease prevention and control measures? ☐ Yes ☐ No

Healthcare provider information

Last name:

First name:

Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA

Facility name:

Address line:

Zip code: City:

State: County:

Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /

Test type: Result date: / / Result: ☐ Positive ☐ Negative

Organism: ***Campylobacter***

Laboratory: Accession #: Collection date: / /

Test type: Result date: / / Result: ☐ Positive ☐ Negative

Organism: ***Campylobacter***

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: Admission date: / / Discharge date: / /

TREATMENT

Antibiotic:
Date started: / /
Dose: Unit:
# of times a day: # of days:

Antibiotic:
Date started: / /
Dose: Unit:
# of times a day: # of days:

Antibiotic:
Date started: / /
Dose: Unit:
# of times a day: # of days:

OCCUPATIONS

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

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:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown

Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

CLINICAL INFO & DIAGNOSIS

Guillain-Barré Diagnosis ☐ Yes ☐ No ☐ Unk Onset Date / /

Reactive Arthritis Diagnosis ☐ Yes ☐ No ☐ Unk Onset Date / /

Symptoms

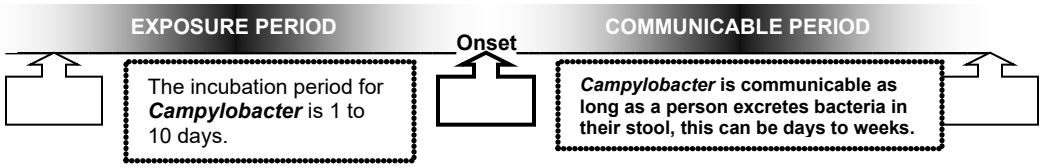
Diarrhea ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Nausea ☐ Yes ☐ No ☐ Unk
Vomiting ☐ Yes ☐ No ☐ Unk
Abdominal cramps ☐ Yes ☐ No ☐ Unk

Visible bloody diarrhea ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Fever ☐ Yes ☐ No ☐ Unk
Highest known fever: _____ ☐ °F ☐ °C

Other Symptoms: Symptoms ongoing: ☐ Yes ☐ No ☐ Unk Date returned to normal activities: / /

INFECTION TIMELINE

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



RISK FACTORS/TRAVEL

In the 10 days prior to onset of symptoms did the case:

Travel within Iowa? ☐ Yes ☐ No ☐ Unk City within Iowa: _____ Departure date: / / Return date: / /

Travel within U.S.? ☐ Yes ☐ No ☐ Unk State: _____ City: _____ Departure date: / / Return date: / /

Travel outside U.S.? ☐ Yes ☐ No ☐ Unk Country: _____ Departure date: / / Return date: / /

Visit restaurants? ☐ Yes ☐ No ☐ Unknown

If Yes, complete the table below:

Establishment name	Address/Zip	Date visited	Foods consumed	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Attend Group Gatherings (e.g. weddings, parties)? ☐ Yes ☐ No ☐ Unknown

If Yes, complete the following table:

Location name	Address/Zip	Date visited	Foods consumed	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Where did the case purchase groceries in the 2 weeks before the onset of symptoms?

Store name	Address	City/State/Zip	County	Date purchased
				/ /
				/ /
				/ /

Dietary Information – *In the 10 days prior to onset of symptoms did the case consume the following:*

Meat and poultry

Any of these meat products? ☐ Poultry ☐ Ground beef ☐ Meat other than ground meat (salami, jerky, wild game)

Was the meat fully cooked? ☐ Yes ☐ No ☐ Unknown

List all source/types: _____

List all brand names: _____

From dates consumed: / / , / / To dates consumed: / / , / /

Other poultry products

Raw/partially cooked eggs or in foods (e.g. cookie dough)**:** ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Unpasteurized products

Unpasteurized milk, juice, cheese, etc.: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Infant formula and baby food ***ask only if child less than 12 months of age*

Infant formula/ baby food: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Animal Exposures – *In the 10 days prior to the onset of symptoms did the case:*

Check all that apply

Visit or live on a farm: ☐ Yes ☐ No ☐ Unknown

Exposed to manure: ☐ Yes ☐ No ☐ Unknown

Have farm animal contact: ☐ Yes ☐ No ☐ Unknown Animals:

Have other animal contact in home: ☐ Yes ☐ No ☐ Unknown Animal: Animal sick: ☐ Yes ☐ No ☐ Unk

Contact with animals in other settings (petting zoo, farm store, county fair, etc.): ☐ Yes ☐ No ☐ Unknown Touched animals: ☐ Yes ☐ No ☐ Unk Animal: _____

Location name: Address/Zip/County:

Water Exposures – *In the 10 days prior to the onset of symptoms did the case:*

Drinking water supply

Drink well water: ☐ Yes ☐ No ☐ Unk If yes, where: ☐ Home ☐ Work ☐ Child Care ☐ School Other specify:

Go swimming? ☐ Yes ☐ No ☐ Unknown

If Yes, complete the table below:

Water Type	Location Type	Dates visited	Facility name / Street address & Zip
☐ Hot tub/spa ☐ Kiddie pool ☐ River/stream ☐ Lake ☐ Pond ☐ Water park ☐ Swimming pool ☐ Water fountain/ splash pad ☐ Other_____	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	From / / To / /	

Other Exposures – *In the 10 days prior to the onset of symptoms did the case:*

Wear diapers ☐ Yes ☐ No ☐ Unk **Have contact with diapers:** ☐ Yes ☐ No ☐ Unk

CONTACTS

Are there close contacts of the case with same symptoms: ☐ Yes ☐ No ☐ Unknown

Close contacts of the case with the same symptoms

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

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

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 exposures	Is contact a case?
☐ Spouse	☐ Sexual contact		/ /	☐ Restaurant	☐ Yes
☐ Child	☐ Family member (non-household)			☐ Gatherings	☐ No
☐ Sibling	☐ Friend/acquaintance			☐ Food	
☐ Roommate	☐ Contact- work/school/etc			☐ Animal	
☐ Parent/ guardian	☐ Unknown/Other			☐ Water	

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

NOTES: