Shigellosis

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

Diagnosis date: / / Onset date: / /

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

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Outbreak name: ____________

Exposure setting: ____________

Epi-linked: ☐ Yes ☐ No ☐ Unk To whom: ____________

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: ***Shigella*** Serotype:

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

Date received: / / Specimen source: ____________ Test type: ________

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: ***Shigella*** Serotype:

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

Date received: / / Specimen source: ____________ Test type: ________

Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative

Organism: ***Shigella*** Serotype:

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:

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:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Admission date: / / Discharge date: / /
Days hospitalized: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____
Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type: _____

CLINICAL INFO & DIAGNOSIS

Date follow up began: / /

Symptoms

Diarrhea ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Nausea ☐ Yes ☐ No ☐ Unk
Abdominal Cramps ☐ Yes ☐ No ☐ Unk
Visible bloody diarrhea ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Fever ☐ Yes ☐ No ☐ Unk _____ Highest known Fever

Date returned to normal activities: / /
Symptoms ongoing at time of interview ☐ Yes ☐ No

OTHER LAB FINDINGS

Clinical specimen from case

Was PFGE performed: ☐ Yes ☐ No ☐ Unk

IA-XbaI Pattern		IA-BlnI Pattern		CDC-XbaI Pattern		CDC-BlnI Pattern	

Environmental specimen testing

Food, Medication, or environmental samples tested? ☐ Yes ☐ No ☐ Unk Describe samples: (circle positives)
For what were the samples tested? ☐ E. coli or EHEC ☐ Salmonella ☐ Shigella ☐ Other testing (specify):
Laboratory: Positive? ☐ Yes ☐ No ☐ Unk PFGE performed? ☐ Yes ☐ No ☐ Unk

IA-XbaI Pattern		IA-BlnI Pattern		CDC-XbaI Pattern		CDC-BlnI Pattern	

TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic:	Antibiotic:	Antibiotic:
Date started: / /	Date started: / /	Date started: / /
Dose:	Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
# of days:	# of days:	# of days:
# of times a day:	# of times a day:	# of times a day:
Route:	Route:	Route:

EXCLUSIONS

Does case attend childcare, therefore needing to be excluded until 1 stool sample tests negative? ☐ Yes ☐ No

Date exclusion is enforced: / /

Report date of 1st negative stool: / /

Date exclusion lifted: / /

Does case work in childcare, healthcare, or food service therefore needing to be excluded until 2 stool samples test negative? ☐ Yes ☐ No

Date exclusion is enforced: / /

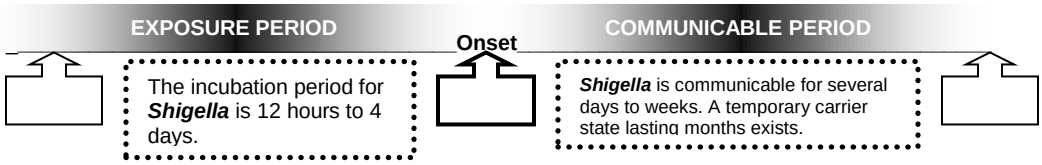
Report date of 1st negative stool: / /

Report date of 2nd negative stool: / /

Date exclusion lifted: / /

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

Risk Factors/Travel Information – *In the 4 days prior to onset of symptoms did the case:*

Travel	Travel within Iowa? ☐ Yes ☐ No ☐ Unk	City in 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
		/ /		☐ Yes ☐ No ☐ Unk

Purchase groceries in the 2 weeks before the onset of symptoms:

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

Dietary Information – *In the 4 days prior to onset of symptoms did the case consume the following:*

Fruits and vegetables

Raw fruits: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Raw vegetables: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Water Exposures – *In the 4 days prior to the onset of symptoms did the case*

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 ☐ Pond ☐ Kiddie pool ☐ Water park ☐ River/stream ☐ Swimming pool ☐ Lake ☐ Water fountain/ splash pad ☐ Other_____	☐ Hotel/motel ☐ Indoor private ☐ Indoor public ☐ Outdoor private ☐ Outdoor public	From / / To / /	

Drinking water supply

In the 3 days prior to the onset of symptoms did the case drink well water? ☐ Yes ☐ No ☐ Unknown

Home:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**School:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well
Work:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**Child care:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well

Other Exposures – *In the 8 days prior to the onset of symptoms did the case:*

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

CONTACTS

Number of people living in case's household: _____

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

Close contacts of the case with the same symptoms

Name

Last: First:

Relationship to case		Symptom onset date
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other	/ /

Name

Last: First:

Relationship to case		Symptom onset date
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other	/ /

NOTES: