Typhoid fever
(including paratyphoid)

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: ______
Facility 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 ☐ Black or African American ☐ Hawaiian or Pacific Islander ☐ Unknown ☐ White ☐ 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: ***Salmonella*** Type (e.g. serotype): ☐ *Typhi* ☐ Paratyphi A ☐ Paratyphi B ☐ Paratyphi C

Laboratory: ______ Accession #: ______ Collection date: / /
Date received: / / Specimen source: ______ Test type: ______
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Salmonella*** Type (e.g. serotype): ☐ *Typhi* ☐ Paratyphi A ☐ Paratyphi B ☐ Paratyphi C

Laboratory: ______ Accession #: ______ Collection date: / /
Date received: / / Specimen source: ______ Test type: ______
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: ***Salmonella*** Type (e.g. serotype): ☐ *Typhi* ☐ Paratyphi A ☐ Paratyphi B ☐ Paratyphi C

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

Admission date: / / Discharge date: / / Days hospitalized: _____

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

OTHER DEMOGRAPHIC INFO

Citizenship: _____ ☐ Unknown

CLINICAL INFO & DIAGNOSIS

Was the patient ill with typhoid or paratyphoid fever? ☐ Yes ☐ No ☐ Unk
Removed "Date of onset" associated with above question. No need for it.

Fever: ☐ Yes ☐No ☐ Unk Fever onset date: / / Duration: Hours/Days

Highest known fever: C/F Rash or rose spots: ☐ Yes ☐No ☐ Unk Onset date: / /

Symptoms:
☐ Abdominal cramps ☐ Diarrhea ☐ Malaise ☐ Rash ☐ Vomiting
☐ Anorexia ☐ Fever ☐ Muscle weakness ☐ Splenomegaly
☐ Chills ☐ Headache ☐ Nausea ☐ Visible bloody diarrhea

OTHER LAB FINDINGS

PFGE Pattern (stool specimen from patient)
Was PFGE performed: ☐ Yes ☐ No ☐ Unk

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

Was antibiotic sensitivity testing performed? ☐ Yes ☐ No ☐ Unk
If Yes, was the organism resistant to:
Ampicillin ☐ Yes ☐ No ☐ Unk
Chloramphenicol ☐ Yes ☐ No ☐ Unk
Tremthoprim-sulfamethozazole ☐ Yes ☐ No ☐ Unk
Floroquinolones ☐ Yes ☐ No ☐ Unk

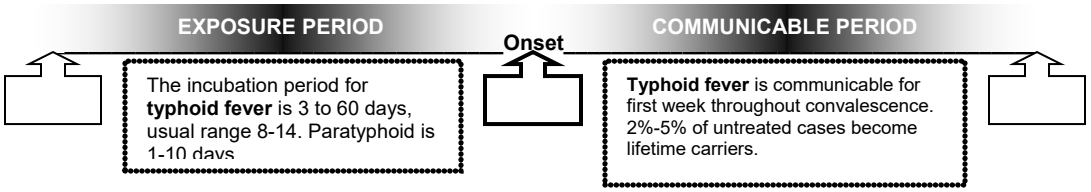
TREATMENT

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 times a day:	# of days: # of times a day:	# of days: # of times a day:
Route:	Route:	Route:

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

Vaccinated for typhoid fever within 5 years of onset: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /	Date vaccinated: / /
Lot #:	Lot #:
Vaccine type: ☐ Killed typhoid shot ☐ Oral Ty21a or Vivotif four pill series ☐ ViCPS or Typhim Vi shot	Vaccine type: ☐ Killed typhoid shot ☐ Oral Ty21a or Vivotif four pill series ☐ ViCPS or Typhim Vi shot
Manufacturer:	Manufacturer:

Number of vaccinations: ____

Risk Factors/Travel Information – *In the 60 days prior to onset of symptoms had the case:*

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk	City in Iowa:	Departure date: / /	Return date: / /
Traveled within U.S.? ☐ Yes ☐ No ☐ Unk	State: City:	Departure date: / /	Return date: / /
Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk	Country:	Departure date: / /	Return date: / /

Lived outside of the United States? ☐ Yes ☐ No ☐ Unknown

Country:	Date of most recent return or entry to the U.S.: / /
Country:	Date of most recent return or entry to the U.S.: / /
Country:	Date of most recent return or entry to the U.S.: / /

What was the purpose of the international travel?

☐ Business
☐ Tourism
☐ Visiting relatives or friends
☐ Immigration to U.S.
☐ Other

Visited restaurants? ☐ Yes ☐ No ☐ Unknown

If Yes, complete the table below: *County and address are missing from this table*

Restaurant	City/State/Zip	Date visited	Foods eaten	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Attended Group Gatherings (e.g. weddings, parties)? ☐ Yes ☐ No ☐ Unknown
If Yes, complete the following table:

Location of gathering	City/State/Zip	Date visited	Foods eaten	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Contact with foreign travelers: ☐ Yes ☐ No ☐ Unknown **Contact with human excreta:** ☐ Yes ☐ No ☐ Unknown

Dietary Information – *In the 60 days prior to onset of symptoms did the case consume the following:*

Seafood

Shellfish: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /
List all source/types: List all brand names:

Unpasturized products

Unpasteurized milk: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /
List all source/types: List all brand names:

Unpasteurized juice: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /
List all source/types: List all brand names:

Other unpasteurized products: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /
List all source/types: List all brand names:

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:

Animal Exposures – *In the 60 days prior to the onset of symptoms did the case have the following exposures:*
Check all that apply

Visit or live on a farm: ☐ Yes ☐ No ☐ Unknown
Exposed to manure: ☐ Yes ☐ No ☐ Unknown
Farm animal contact: ☐ Yes ☐ No ☐ Unknown Animals:
Reptile contact: ☐ Yes ☐ No ☐ Unknown ☐ Iguana ☐ Lizard ☐ Turtle ☐ Snake ☐ Other _____
Reptile lived with case: ☐ Yes ☐ No ☐ Unknown

CONTACTS

Number of people living in case's household: ____

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

Close contacts with similar symptoms and/or exposures

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.

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	

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	/ /	☐ Male ☐ Female	Zip code: Phone: - -

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	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case:		List symptoms	Symptom onset date	Same exposures	Is contact a case?
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☐ 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: ______________________________