BOTULISM INVESTIGATION FORM

☐ FOODBORNE BOTULISM ☐ INFANT BOTULISM ☐ WOUND BOTULISM ☐ OTHER BOTULISM

PERSON PROVIDING INFORMATION

Name of Person Being Interviewed: ________________ Relationship to Patient: ________________ Preferred Language: __________

If patient is less than 18 years old, provide parent/proxy's name: ____

Has the patient or patient's proxy been notified by the reporter of this diagnosis or lab result? No Unknown Yes

BASIC DEMOGRAPHIC DATA

First Name:________________________________ Middle Name:_________________________ Last Name:_______________________

DOB: __ __/ __ __/__ __ __ __ Age: _______ years months Current Sex: Female Male Unknown

Marital Status: Married Single, never married Widowed Annulled
Domestic partner Interlocutory Legally separated Divorced
Polygamous Refused to answer Unknown

Is the patient deceased? No Unknown Yes Date of Death: __ __/ __ __/__ __ __ __

Street Address 1:____ Street Address 2:_______________________________________

City:____ State:_______ Zip Code:________________

County:_________________________________ Country of birth:______________

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _______

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Race: American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Islander White
Unknown Black/African American

Primary Occupation: ____________________________________ Industry:____

Name and location of employer: ____
____
____

INVESTIGATION SUMMARY

Jurisdiction: _______________________ Investigation Start Date: __ __/ __ __/__ __ __ __ Investigation Status: Open Closed
Investigator:_______________________

REPORTING SOURCE

Date of Report: __ __/ __ __/__ __ __ __ Reporting Source:____

CLINICAL

Physician's Name:_______________________________________ Phone Number: (___) - ____ - _____ Ext. ______

Was patient hospitalized for this illness? No Unknown Yes If yes: Hospital Name:___________________________________

Admission Date: __ / __ /____ Discharge Date: __ / __ /____ Duration of Stay __________ day(s)

Diagnosis Date: __ / __ /____ Illness Onset Date: __ / __ /____ Illness End Date: __ / __ /____

Age at Onset: _________ days hours minutes months unknown weeks years

Did the patient die from this illness? No Unknown Yes Date of Death: __ / __ /____

EPIDEMIOLOGIC

Is this patient a food handler? No Unknown Yes

Is this case part of an outbreak? No Unknown Yes If yes, outbreak name:___________________________________

Case Status: Confirmed Not a Case Probable MMWR Week: ___________ MMWR Year:___________

Disease Acquisition

Where was the disease acquired?: ☐ Imported, Undetermined Source State/County ☐ Indigenous ☐ International

☐ In State, Out of Jurisdiction ☐ Out of State ☐ Unknown

Imported Country: ___________________ Imported State: _________________________ Imported City: _____________

Imported County: ________________________________

FOODBORNE BOTULISM INVESTIGATION QUESTIONS *(skip to next section if not Foodborne)*

Symptoms

Abdominal Pain: No Unknown Yes Nausea: No Unknown Yes Vomiting: No Unknown Yes

Diarrhea: No Unknown Yes Blurred vision: No Unknown Yes Diplopia: No Unknown Yes

Photophobia: No Unknown Yes Dysphasia: No Unknown Yes Dysphonia: No Unknown Yes

Muscle Weakness: No Unknown Yes If yes to muscle weakness, specify: ______________________________

Dyspnea: No Unknown Yes Fatigue: No Unknown Yes Dry Mouth: No Unknown Yes

Urinary Retention: No Unknown Yes Constipation: No Unknown Yes Dizziness: No Unknown Yes

Paresthesias: No Unknown Yes If yes to paresthesias,specify where: ______________________________

Convulsions: No Unknown Yes Other Symptoms: ______________________________________

Signs

Ptosis: No Unknown Yes Extraocular palsy: No Unknown Yes

Fixed pupils: No Unknown Yes If 'yes' to fixed pupils specify: ________________________

Decreased corneal reflex: No Unknown Yes Facial paralysis: No Unknown Yes

Symmetrical facial paralysis: No Unknown Yes Decreased gag reflex: No Unknown Yes

Weakness/paralysis of extremities: No Unknown Yes If 'yes' to weakness/paralysis specify: ___________________

Decreased ability to protrude tongue: No Unknown Yes

Sensory findings: No Unknown Yes If 'yes' to sensory findings, specify: ___________________

Ataxia: No Unknown Yes Symmetrical ataxia: No Unknown Yes

DTRs: No Unknown Yes If yes to DTR's, specify: __________________________

Nystagmus: No Unknown Yes Respiratory impairment: No Unknown Yes

Tracheostomy: No Unknown Yes Vital capacity: No Unknown Yes

Abnormal mental status: No Unknown Yes Fever (>100.4°F) No Unknown Yes

Wound Information

Does the patient have a wound? No Unknown Yes If yes, where is the wound? ____________________

When was the wound sustained? _________________ How was the wound treated? ____________________

Drugs Taken Information

Did this patient take antibiotics, anticholinergics, or phenothiazines during the last week? No Unknown Yes

List meds: ____

Differential Diagnosis: ***Were the following conditions considered and ruled out?***

Stroke (CVA) No Unknown Yes If yes, what test was done: ______________ Results: ___________

Guillain-Barre Syndrome No Unknown Yes If yes, what test was done: ______________ Results:___________

Myasthenia gravis No Unknown Yes If yes, what test was done: ______________ Results:___________

Tick paralysis No Unknown Yes If yes, what test was done: ______________________ Results:________________
Lambert-Eaton syndrome No Unknown Yes If yes, what test was done: ______________________ Results:________________
Toxic exposures No Unknown Yes If yes, what kind of exposure ____________________ Results:________________
Poliomyelitis No Unknown Yes If yes, what test was done: ______________________ Results:________________

Notified:

State epidemiologist: No Unknown Yes Date: __ __/__ __/__ __ __ __
BCL No Unknown Yes Date: __ __/__ __/__ __ __ __
CDC No Unknown Yes Date: __ __/__ __/__ __ __ __
CDC Infant Botulism No Unknown Yes Date__ __/__ __/__ __ __ __
FDA No Unknown Yes Date__ __/__ __/__ __ __ __
USDA No Unknown Yes Date__ __/__ __/__ __ __ __

Diagnosis

Tentative diagnosis: ____

Current status of Patient ____

What diagnoses have been ruled out? ____

Recommendations by EIS Officer

Induce emesis: No Unknown Yes Purgation: No Unknown Yes Antitoxin: No Unknown Yes
Antibiotics: No Unknown Yes Surgery: No Unknown Yes Other recommendations: No Unknown Yes

Clinical Criteria for Case Classification

Does the patient have diplopia, blurred vision, and bulbar weakness and is symmetric descending paralysis present? No Unknown Yes

Did the patient ingest the same food as another patient with a laboratory-confirmed case? No Unknown Yes

Did the patient have any other epidemiologic link without laboratory confirmation? No Unknown Yes

Description of link: ____

Laboratory Criteria for Case Classification

Was botulinum toxin detected in serum, stool, or patient's food? No Unknown Yes

Was *Clostridium botulinum* isolated from stool? No Unknown Yes

PHEP PROJECT - GENERAL

Date of presumptive diagnosis: __ __/__ __/__ __ __ __

CONTROL MEASURES IMPLEMENTED (Answer all)

Date first control measures initiated: __ __/__ __/__ __ __ __ Other measures: ______________________________

Education case/contacts: No Unk Yes N/A Exclusions from food handling: No Unk Yes N/A
Exclusions from healthcare: No Unk Yes N/A Exclusions from daycare/school: No Unk Yes N/A
Immunization: No Unk Yes N/A Prophylaxis: No Unk Yes N/A
Identification of exposed individuals: No Unk Yes N/A Identification of additional cases: No Unk Yes N/A
Identification of likely source of infection: No Unk Yes N/A Collection of food: No Unk Yes N/A
Notify state/federal partner agencies/organizations: No Unknown Yes N/A

DAY CARE

Is this patient associated with a day care facility? No Unknown Yes

Attend a day care center? No Unknown Yes Work at a day care center? No Unknown Yes

Live with a day care center attendee? No Unknown Yes What is the name of the day care facility? ________________________

What type of day care facility? Adult day health care Adult day social care Alzheimer's specific day care
Child care center Child care provided by friend, relative, neighbor In-home care giver

Is food prepared at this facility? No Unknown Yes Does this facility care for diapered persons? No Unknown Yes

DRINKING WATER EXPOSURE

What is the source of tap water at home? Do not use tap water Municipal, city, or county Other________ Private well Unknown

If "Private Well", how was home well water treated? Both filtered and disinfected Disinfected Filtered Neither filtered nor disinfected Unknown

What is the source of tap water at school/work? Do not use tap water Municipal, city, or county Other________ Private well Unknown

If "Private Well", how was school/work well water treated? Both filtered and disinfected Disinfected Filtered Neither filtered nor disinfected Unknown

Did the patient drink untreated water in the 7 days prior to onset of illness (e.g., from a river while camping)? No Unknown Yes

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

CSF leak	Hodgkin's disease	IVDU
Alcohol abuse	Asthma	Atherosclerotic cardiovascular disease (ASCVD)/CAD
Burns	Cerebral vascular accident (CVA) stroke	Chronic GI illness/diarrhea
Cirrhosis/liver failure	Cochlear implant	Current smoker
Deaf/profound hearing loss	Diabetes mellitus (insulin-dependent)	Emphysema/COPD
Gastric surgery (type): _____________	Heart failure	Hematologic disease (type): _____________________
Immunodeficiency (type): __________	Immunoglobulin deficiency	Immunosuppressive therapy (steroids, chemotherapy)
Leukemia	Multiple myeloma	Nephrotic Syndrome
None	Organ transplant (organ): ______________	Other liver disease (type): _____________________
Other malignancy (type): __________	Other prior illness (type): ______________	Other renal disease (type): _____________________
Peptic ulcer	Renal failure/dialysis	Sickle cell anemia
Splenectomy/asplenia	Systemic lupus erythematosus (SLE)	Unknown

RELATED CASES

Does the patient know of any similarly ill persons? No Unknown Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further? No Unknown Yes

Are the other cases related to this one? No, sporadic Unknown Yes, household Yes, not household Yes, outbreak

OTHER CLINICAL DATA

Was botulism laboratory confirmed from a patient specimen? No Unknown Yes

Was *C. botulinum* isolated in culture from a patient specimen? No Unknown Yes

If food is known or thought to be the source:

Please specify food type: Commercial Home canned Other:____________________________ Other home cooked

Was food tested? No Unknown Yes

If food was positive, what was its toxin type: A B E F Other:____

ADMINISTRATIVE

General Comments:____

____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: Reviewed (Complete) Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ Reviewed (Not a case) Yes

Review comments (completed by supervisor):____

State Epidemiologist's Recommendations:

____

____

Create the appropriate ALNBS investigation: 1. Botulism, foodborne, 2. Botulism, infant, 3. Botulism, other/unspecified, or 4. Botulism, wound.

Clinical syndrome

The clinical syndrome of botulism, whether foodborne, infant, wound, or intestinal colonization, is dominated by the neurologic symptoms and signs resulting from a toxin-induced blockade of the voluntary motor and autonomic cholinergic junctions and is quite similar for each cause and toxin type. Incubation periods for foodborne botulism are reported to be as short as 6 hours or as long as 10 days, but generally the time between toxin ingestion and onset of symptoms ranges from 18 – 36 hours.

Types of Botulism: Foodborne, Wound, Infant, Child or adult botulism from intestinal colonization.

Diagnosis/Signs & Symptoms Adult

- Acute onset of gastrointestinal autonomic (ex. Dry mouth, difficulty focusing)
- Cranial nerve (diplopia, dysarthria, dysphagia) dysfunction
- Descending peripheral muscle weakness
- Ventilatory compromise

Diagnosis/Signs & Symptoms Infant/Child

- Poor feeding, diminished suckling and crying ability
- Constipation is often seen in infants and in some has preceded the onset of neurologic abnormalities by many days.
- Neck and Peripheral weakness (floppy babies)
- Loss of facial expression
- Extraocular muscle paralysis, dilated pupils
- Depression of deep tendon reflexes
- Ventilatory failure

Important Phone Numbers:

- **General CDC 1-800-232-4636**
- **National Botulism Surveillance 1-404-639-2206**
- **Infant Botulism 1-510-231-7600**
- **Consult with CDC National Center for Environmental Health and Agency for Toxic Substances and Disease Registry. 24/7 1-770-488-7100**
- **BCL 1-334-260-3400**