

CAMPYLOBACTERIOSIS INVESTIGATION FORM

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

Last Name: _____ First Name: _____ Middle Name: _____

DOB: ___/___/___ Age: _____years months Current Sex: Female Male Unknown

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

Street Address 1: _____ Street Address 2: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ Ext. _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

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

INVESTIGATION SUMMARY

Investigation Start Date: ___/___/___ Investigation Status: Open Closed Investigator: _____

REPORTING SOURCE

Date of Report: ___/___/___ Reporting Source: _____

Earliest Date Reported to County: ___/___/___ Earliest Date Reported to State: ___/___/___

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: ___/___/___

Is the patient pregnant? No Unknown Yes

Does the patient have pelvic inflammatory disease? No Unknown Yes

SIGNS AND SYMPTOMS

Diarrhea: No Unknown Yes

EPIDEMIOLOGIC

Is this patient associated with a day care facility? No Unknown Yes 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 Suspect Unknown MMWR Week: _____ MMWR Year: _____

Where was the disease acquired? _____

Transmission Mode: _____

Detection Method: _____

Confirmation Date: _____

DAY CARE

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

FOOD HANDLER

Did the patient work as a food handler after onset of illness? No Unknown Yes

What was the last date worked as a food handler after onset of illness? __/___/____

Where was the patient a food handler? _____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? No Unknown Yes Applicable incubation period for this illness is: **1 – 10 days**

What was the purpose of travel? Business Migration (immigration to US) Other _____ Tourism Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: Domestic State/Territory: _____ International Country: _____

Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: __/___/____ Departure Date: ___/ __/ ____

Destination 2 Type: Domestic State/Territory: _____ International Country: _____

Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: __/___/____ Departure Date: ___/ __/ ____

Destination 3 Type: Domestic State/Territory: _____ International Country: _____

Mode of Travel: Airplane Bus Car Cruise ship Train Arrival Date: __/___/____ Departure Date: ___/ __/ ____

If more than 3 destinations, specify details here: _____

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 **10 days** prior to onset of illness (e.g., from a river while camping)? No Unknown Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **10 days** prior to illness? No Unknown Yes

What was the recreational water exposure type? (select all that apply)

Hot Spring Hot Tub-Whirlpool-Jacuzzi-Spa Interactive Fountain Lake-Pond-River-Stream
Ocean Other _____ Recreational Water Park Swimming Pool

If “Swimming Pool”, please specify swimming pool type:

Camp Pool Hospital/Therapy Pool Hotel/Motel/Resort Vacation Pool
Kiddie/Wading Pool Municipal/Community Pool Neighborhood/subdivision/Apartment/Condo Pool
Other, specify _____ Private Club/Membership Pool Private Home Pool, not a kiddie/wading pool
School/College/University Pool Unknown

Name or location of water exposure: _____

ANIMAL CONTACT

Did the patient come into contact with an animal in the **10 days** prior to onset of illness? No Unknown Yes

If yes, select type of animal: Cat Cattle Chicken Dog Goats Lizard
Poultry Rodent Sheep Swine Turtle Unknown
Other, specify: _____

Name or location of animal contact: _____

Did a patient come into contact with animal food/feed(s) in the **10 days** prior to onset of illness? No Unknown Yes

If yes, select associated animal food/feed(s): Cat Cattle Chicken Dog Goats Lizard
Poultry Rodent Sheep Swine Turtle Unknown
Other, specify: _____

If applicable, please list food brand(s): _____

UNDERLYING CONDITIONS

Did the patient have any of the following underlying conditions?

<input type="checkbox"/> CSF leak	<input type="checkbox"/> Hodgkin's disease	<input type="checkbox"/> IVDU
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/> Asthma	<input type="checkbox"/> Atherosclerotic cardiovascular disease (ASCVD)/CAD
<input type="checkbox"/> Burns	<input type="checkbox"/> Cerebral vascular accident (CVA) stroke	<input type="checkbox"/> Chronic GI illness/diarrhea
<input type="checkbox"/> Cirrhosis/liver failure	<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> Current smoker
<input type="checkbox"/> Deaf/profound hearing loss	<input type="checkbox"/> Diabetes mellitus (insulin): <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Yes	<input type="checkbox"/> Emphysema/COPD
<input type="checkbox"/> Gastric surgery (type): _____	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Hematologic disease (type): _____
<input type="checkbox"/> Immunodeficiency (type): _____	<input type="checkbox"/> Immunoglobulin deficiency	<input type="checkbox"/> Immunosuppressive therapy (steroids, chemotherapy)
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Multiple myeloma	<input type="checkbox"/> Nephrotic Syndrome
<input type="checkbox"/> None	<input type="checkbox"/> Organ transplant (organ): _____	<input type="checkbox"/> Other liver disease (type): _____
<input type="checkbox"/> Other malignancy (type): _____	<input type="checkbox"/> Other prior illness (type): _____	<input type="checkbox"/> Other renal disease (type): _____
<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Renal failure/dialysis	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Splentectomy/asplenia	<input type="checkbox"/> Systemic lupus erythematosus (SLE)	<input type="checkbox"/> 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

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the NEDSS Investigation.

OTHER CLINICAL DATA

Was the isolate identified as *Campylobacter*? No Not Tested Unknown Yes

What was the EIA result at clinical (i.e., non-public health) laboratory? Indeterminate Negative Not Tested Positive

What was the PCR result at clinical (i.e., non-public health) laboratory? Indeterminate Negative Not Tested Positive

What was the species result at clinical laboratory (e.g., *Campylobacter jejuni*)? _____

What was the EIA result at State Public Health Laboratory (SPHL)? Indeterminate Negative Not Tested Positive

What was the PCR result at State Public Health Laboratory (SPHL)? Indeterminate Negative Not Tested Positive

What was the species result at State Public Health Laboratory (SPHL) (e.g., *C. jejuni*)? _____

What was the PCR result at Centers for Disease Control & Prevention (CDC)? Indeterminate Negative Not Tested Positive

Did the patient have bloody diarrhea during this illness? No Unknown Yes

Did the patient have diarrhea (self-reported)? No Unknown Yes

Did the patient have fever (self-reported) during this illness? No Unknown Yes

ADMINISTRATIVE

JEFFERSON COUNTY 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): _____