

LISTERIOSIS INVESTIGATION FORM

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: ___/___/_____

Marital Status: Annulled Common Law Divorced Domestic partner Interlocutory Legally Separated Living Together Married
Polygamous Refused to answer Separated Single, never married Unknown Unmarried Unreported
Widowed Other

SSN: _____-_____-_____

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: _____
Date Assigned to Investigation: ___/___/_____

REPORTING SOURCE

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

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

Is the patient pregnant? No Unknown Yes

Does the patient have pelvic inflammatory disease? No Unknown Yes

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

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: _____

Where was the disease acquired? Indigenous, within jurisdiction Out of country Out of jurisdiction, from other jurisdiction
Out of state Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Transmission Mode: Airborne Bloodborne Dermal Foodborne Indeterminate Mechanical Nosocomial Sexually Transmitted
Transplacental transmission Vectorborne Waterborne Zoonotic Unknown

Detection Method: Active Surveillance Case/Outbreak Investigation Clinical diagnosis (non-laboratory confirmed)
Epidemiologically linked Laboratory confirmed Laboratory report Local/State specified Medical record review
No information given Occupational disease surveillance Provider certified Other

Confirmation Date: ___/___/_____

Case Status: Confirmed Not a Case Probable Suspect Unknown MMWR Week: _____ MMWR Year: _____

ADMINISTRATIVE

General Comments: _____

CUSTOM FIELDS

(For State-level Use Only) ARWFTI: _____

(For State-level Use Only) CSV: _____

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): _____

LABORATORY REQUEST

Was laboratory contacted to request isolate being sent to state public laboratory (BCL)? No Yes

Date laboratory contacted: ___/___/_____

If specimen not sent to BCL, please explain: _____

CONTROL MEASURES

Date ADPH Investigator verbally provided patient, or patient representative, with Control Measures: ___/___/_____

If control measures were not verbally provided (or not provided within the recommended timeframe), explain:

Educations case/contacts: Yes No Not applicable

Identification of additional cases/exposed individuals and contact tracing: Yes No Not applicable

CLINICAL EVIDENCE

Meningitis as a result of Listeria monocytogenes infection: No Unknown Yes

DAY CARE

1. Attend a day care center? No Unknown Yes

If no, move to question 2

If yes, 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

What is the name of the day care facility? _____

Is food prepared at this facility? _____

Does this facility care for diapered persons? _____

2. Work at a day care center? No Unknown Yes

If no, move to question 3

If yes, 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

What is the name of the day care facility? _____

Is food prepared at this facility? _____

Does this facility care for diapered persons? _____

3. Live with a day care center attendee? No Unknown Yes

If yes, 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

What is the name of the day care facility? _____

Is food prepared at this facility? _____

Does this facility care for diapered persons? _____

TRAVEL HISTORY

Did the patient travel prior to onset of illness? No Unknown Yes

If no, SKIP and move to next section

If yes, applicable incubation period for this illness is: _____ days

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

Please specify the destination(s):

Destination 1 Type: Domestic International

Destination 1: _____

Mode of Travel: Airplane Bus Car Cruise Ship Train

Date of Arrival: ___/___/_____

Date of Departure: ___/___/_____

Destination 2 Type: Domestic International

Destination 2: _____

Mode of Travel: Airplane Bus Car Cruise Ship Train

Date of Arrival: ___/___/_____

Date of Departure: ___/___/_____

Destination 3 Type: Domestic International

Destination 3: _____

Mode of Travel: Airplane Bus Car Cruise Ship Train

Date of Arrival: ___/___/_____

Date of Departure: ___/___/_____

If more than 3 destinations, specify details here:

PREGNANCY

Is this a pregnancy related case? No Unknown Yes

If yes, type of infection in mother: Amnionitis Bacteremia-sepsis Febrile gastroenteritis No symptoms
Other (specify) _____ Unknown

Comments on infection in mother:

Outcome of pregnancy: Miscarriage Pre-term delivery (live birth) Still pregnant Stillbirth Term delivery (live birth) Unknown
Other (specify) _____

Comments on pregnancy outcome:

Confirmed Listeria in neonate or fetus? No Unknown Yes

Source of specimen collected from fetus/neonate: Cerebral spinal fluid Placenta Whole blood Unknown Other (specify) _____

Fetus/neonate specimen collection date: ___/___/_____

Type of infection in fetus/neonate: Bacteremia-sepsis Granulomatosis infantisepticum Unknown
 Other (specify) _____

Comments on infection in fetus/neonate:

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"/> Splenectomy/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 there other cases related to this one? No, sporadic Yes, household Yes, not household Yes, outbreak Unknown

OTHER CLINICAL DATA

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

CDC LISTERIA INITIATIVE CASE REPORT FORM

Please complete the CDC *Listeria* Initiative Case Report Form beginning on page 5.