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

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:_____

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 another jurisdiction
☐Out of State ☐Unknown

If selection is out of country, state, or jurisdiction, 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: ☐Patient self-referral ☐Prenatal testing ☐Prison entry screening ☐Provider reported ☐Routine physical ☐Other

Confirmation 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 ☐Probable ☐Not a Case ☐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

Salmonella serotype: _____

ASSOCIATED CASES

Is this case epidemiologically linked to a Confirmed case, Probable case, or part of a known Salmonella outbreak? ☐No ☐Unknown ☐Yes

If yes, enter the associated NBS Investigation ID(s): _____, _____,

_____, _____, _____,

_____

EXPOSURES

What is the patient's primary occupation? _____

Name and location of employer:

_____

_____

Did the patient receive typhoid vaccination within five years before onset of illness? ☐No ☐Unknown ☐Yes

If yes, indicate type of vaccine received (oral pills or injection/shot): ☐Oral Ty21a or Vivotif (Berna) four pill series Year received: __ __ __ __
☐ViCPS or Typhim Vi shot (Pasteur Merieux) Year received: __ __ __ __

Is the patient a U.S. Citizen?: ☐No ☐Unknown ☐Yes

If not a U.S. Citizen, country of origin: _____

Was the patient symptomatic for Typhoid or Paratyphoid Fever?: ☐No ☐Unknown ☐Yes

Was the case traced to a Typhoid or Paratyphoid carrier?: ☐No ☐Yes, carrier previously known to HD ☐Yes, carrier previously unknown to HD
☐Yes, unknown if carrier previously known to HD ☐Unknown

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

Exclusion from food handling, healthcare, and/or daycare: ☐Yes ☐No ☐Not applicable

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

DAY CARE

1. Does the patient attend a day care center? ☐No ☐Unknown ☐Yes

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

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

If yes to any of the above, name of 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

What is the name of the day care facility? _____

Is food prepared at this facility? _____

Does this facility care for diapered persons? _____

FOOD HANDLER

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

If yes, last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __

Where was the patient a food handler? _____

TRAVEL HISTORY

Did the patient travel outside the U.S. within **30 days** 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:

_____

_____

_____

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

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **7 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 in contact with an animal? ☐No ☐Unknown ☐Yes

If yes, select type of animal: ☐Cat ☐Cattle ☐Chicken ☐Dog ☐Domestic pig ☐Goats ☐Lizard ☐Other (specify) _____
☐Other amphibian (specify) _____ ☐Other mammal (specify) _____
☐Other reptile (specify) _____ ☐Rodent ☐Sheep ☐Turkey ☐Turtle
☐Wild boar/feral pig ☐Unknown

Name or Location of Animal Contact:

_____

Did the patient acquire a pet prior to onset of illness? ☐No ☐Unknown ☐Yes

Applicable incubation period for this illness is: _____

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):☐No ☐Unk ☐Yes ☐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

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

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