SHIGELLOSIS 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: __ __/ __ __/__ __ __ __

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: __ __/ __ __/__ __ __ __ State: __ __/ __ __/__ __ __ __ Reporter:_______________

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

Transmission mode: Airborne Blood borne Thermal Foodborne Indeterminate Mechanical Nosocomial Sexually Transmitted Transplacental transmission Vectorborne Waterborne Zoonotic Other

Detection method: Patient Self-Referral Prenatal Testing Prison Entry Screening Provider Reported Routine Physical Other

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

Confirmation Date: __ __/ __ __/__ __ __ __

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

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):____

LABORATORY

Shigella species, if known: boydii dysenteriae flexneri sonnei Date of Interview: __ __/ __ __/__ __ __ __

Associated Cases

Is this case epidemiologically linked to an individual with laboratory evidence of shigellosis or is it part of a known Shigella outbreak?
No Unknown Yes If yes, enter the associated NBS Investigation ID(s) or Outbreak ID :__________________________________

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: No Not Applicable Yes

Exclusion from food handling, healthcare, and/or daycare: No Not Applicable Yes
Identification of additional cases/exposed individuals and contact tracing: No Not Applicable Yes

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 Does this facility care for diapered persons? No Unknown Yes

FOOD HANDLER

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

TRAVEL HISTORY

Did the patient travel prior to onset of illness? No Unknown Yes Applicable incubation period for this illness is: **1 – 7 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 **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 into contact with an animal in the **7 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 **7 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?

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

FoodNet

FoodNet Case

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