Typhoid and Paratyphoid Fever Investigation Form

☐ Typhoid Fever (Create ALNBS Typhoid Fever Investigation) ☐ Paratyphoid Fever (Create ALNBS Paratyphoid fever Investigation)

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:_____

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

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

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):_____

CLINICAL EVIDENCE

Fever: ☐ No ☐ Unknown ☐ Yes Relative Bradycardia: ☐ No ☐ Unknown ☐ Yes

Diarrhea: ☐ No ☐ Unknown ☐ Yes Abdominal Pain: ☐ No ☐ Unknown ☐ Yes

Constipation: ☐ No ☐ Unknown ☐ Yes

Anorexia: ☐ No ☐ Unknown ☐ Yes

EXPOSURES

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

If Antibiotic sensitivity testing was performed, was isolate resistant to: ☐ Ampicillin ☐ Trimethoprim-sulfamethoxazole ☐ Chloramphenicol ☐ Fluoroquinolones (e.g., Ciprofloxacine)

If patient received Typhoid vaccination, was it administered within **5 years** before illness onset? ☐ No ☐ Unknown ☐ Yes

Typhoid vaccine received: ☐ Standard killed ☐ Oral Ty21a or Vivotif (Berna) 4 pill series ☐ ViCPS or Typhim Vi shot (Pasteur Merieux)

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

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

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 **14 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 **14 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: _____

SEAFOOD EXPOSURE

Has the patient eaten seafood in the last **14 days**? ☐ No ☐ Unknown ☐ Yes

Date raw seafood consumed: __ __ / __ __ / __ __ __ __ Time raw seafood consumed: __ __ : __ __ ☐ AM ☐ PM

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

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

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

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