Centers for Disease Control and Prevention
1600 Clifton Road, MS C09, Atlanta, GA 30333
Fax: 404-639-2205

BOTULISM CASE REPORT

REPORTING AGENCY

Officer Releasing Antitoxin	Health Agency	Telephone Number	Today's Date
			___ ___ _____

Date of First Report	First Reported By	State Contact (if applicable)
___ ___ _____		

Treating Physician/Contact for H-BAT Release Name- Last Name, First Name	Telephone Number	Fax Number / Email	Specialty
		Fax Number Email	☐Internist ☐Intensivist ☐Neurologist ☐Infectious Disease ☐Pediatrician ☐Other _____
Attending Physician Name - Last Name, First Name	Telephone Number	Fax Number Email	Specialty ☐Internist ☐Intensivist ☐Neurologist ☐Infectious Disease ☐Pediatrician ☐Other _____

DEMOGRAPHIC INFORMATION

Patient Name - Last Name, First Name, Middle Initial:	Patient's Telephone Number	Patient's E-mail Address

Patient's Street Address	City	State	Zip Code

Date of Birth	Age	Sex	Ethnicity	Race (check all that apply)		
___ ___ _____	_____ ☐Months ☐Years	☐Male ☐Female	☐Non-Hispanic/Non-Latino ☐Hispanic/Latino ☐Unknown	☐African-American/Black ☐American Indian	☐Asian ☐Pacific Islander ☐White	☐Alaska Native ☐Other_____ ☐Unknown

CLINICAL INFORMATION

Symptomatic?	Onset Date of First Botulism Symptom	Onset Hour (military)	Onset Date of Neurologic Symptoms	Date First Sought Medical Care	Currently Hospitalized?	If yes, Admit date
☐Yes ☐No ☐Unk		___ ___			☐Yes ☐No ☐Unk	

Hospital Name	City	State	Zip Code	Telephone Numbers

Admitted to ICU? ☐Yes ☐No ☐Unk If yes, date	Placed on Ventilator? ☐Yes ☐No ☐Unk If yes, date ___ ___ _____	Additional Hospital Phone Numbers (e.g., Pharmacy and ICU)

CLINICAL PRESENTATION

Vital Signs (upon presentation)

Temperature (°F) _____ Blood Pressure (mmHg) _____/_____ Heart Rate (beats/min.) _____ Respiration Rate (breaths/min.) _____

Symptoms	Yes	No	Unk	Physical Exam Findings	Yes	No	Unk
Nausea				Alert and Oriented			
Vomiting				Extraocular Palsy (paralysis of eye muscles)			
Abdominal Pain				If yes, is it bilateral?			
Diarrhea				If bilateral, is it symmetric?			
Constipation				Ptosis (drooping eyelids)			
Blurred Vision				If yes, is it bilateral?			
Diplopia (double vision)				If bilateral, is it symmetric?			
Dizziness				Pupils dilated (mm=)			
Slurred Speech				If yes, is it bilateral?			
Thick tongue				Pupils constricted (mm=)			
Change in sound of voice				If yes, is it bilateral?			
Hoarseness				Pupils non-reactive			
Dry mouth				If yes, is it bilateral?			
Dysphagia (difficulty swallowing)				Facial Paralysis			
Shortness of breath				If yes, is it bilateral?			
Subjective weakness				If bilateral, is it symmetric?			
Fatigue				Palatal weakness			
Paresthesia (abnormal sensation, e.g. numbness)				If yes, is it bilateral?			
Urinary Retention				Impaired gag reflex			
Other Symptoms (specify):				Sensory deficit(s) If yes, specify			
				Other (specify):			

Comments / Remarks:

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Revised March 2013

Musculoskeletal Exam: (*0=no evidence of contractility; 1=slight contractility, no movement; 2=full range of motion, gravity eliminated; 3=full range of motion w/ gravity; 4=full range of motion against gravity, some resistance; 5=full range of motion against gravity, full resistance*)

Proximal Upper Extremity	Distal Upper Extremity	Proximal Lower Extremity	Distal Lower Extremity
R:__/5 L:__/5 ☐Unk	R:__/5 L:__/5 ☐Unk	R:__/5 L:__/5 ☐Unk	R:__/5 L:__/5 ☐U

Deep Tendon Reflexes: (*0=No response; 1=sluggish or diminished; 2=active or expected response; 3=more brisk than expected, slightly hyperactive; 4=brisk, hyperactive, with intermittent or transient clonus*)

Biceps/Triceps	Brachial	Patellar	Ankle
R:__/4 L:__/4 ☐Unk	R:__/4 L:__/4 ☐Unk	R:__/4 L:__/4 ☐Unk	R:__/4 L:__/4 ☐Unk

If muscle weakness/paralysis present, describe progression.

☐Ascending, ending with cranial nerves ☐Descending, beginning with cranial nerves ☐Other: _____

Clinical Tests	Yes	No	Unk	If yes, specify as noted
Lumbar puncture CSF analysis				Date ____ ____ _____ WBC count _____ RBC_____ Glucose _____ Protein _____
				Repeat Lumbar puncture? ☐Yes ☐No ☐Unk If yes, specify as noted: Date ____ ____ _____ WBC count _____ RBC_____ Glucose _____ Protein _____
EMG				Date ____ ____ _____ Done with rapid, repetitive stimulation ☐Yes ☐No ☐Unk If yes, at what hertz? _____ Check one: ☐Suggestive of/consistent with botulism ☐Not consistent with botulism ☐Unk
Edrophonium (Tensilon)				Date ____ ____ _____ Describe test results:
CT scan or MRI scan				☐Head ☐Spine ☐Other _____ Suggestive of diagnosis other than botulism ☐Yes ☐ No ☐Unk Describe:_____

Past Medical History

Prior Botulism Diagnosis?	*If yes, date*	*Medications that could cause neuromuscular paralysis used within 30 days before illness onset (check all that apply).*
☐Yes ☐No ☐Unk		☐Myobloc (toxin type B) ☐Aminoglycoside (e.g. gentamicin,tobramycin) ☐Other _____ ☐Botox (toxin type A) ☐Anticholinergic ☐Other _____

Prior Neurologic Impairment?	*If yes, specify*	*Does the patient have an allergy to equine products?*	*If yes. describe*
☐Yes ☐No ☐Unk	_____	☐Yes ☐No ☐Unk	

Differential Diagnosis per attending MD *(Please place a 1 for the most likely diagnosis, 2 for the second most likely, and 3 for the third most likely)*

____Botulism	____Tick paralysis	____Paralytic shellfish poisoning
____Myasthenia gravis	____Eaton-Lambert syndrome	____Other_____
____Guillain-Barré syndrome	____Stroke or central nervous system mass or lesion	____Other_____

EPIDEMIOLOGIC INFORMATION

Travel History

*Did patient travel **outside county of residence** within 15 days prior to illness onset?* ☐Yes ☐No ☐Unk

If yes, specify all locations and dates below.

Location (city, county, state, country)	*Dates of Travel*
	to ___ ___ _____
	___ ___ _____ to ___ ___ _____
	___ ___ _____ to ___ ___ _____

Contacts/ Other Ill Persons

Any contacts with similar illness? ☐Yes ☐No ☐Unk — *If yes, complete table below*:

Name	*Age*	*City, State*	*Onset Date*	*Relationship*
	Sex	*Telephone Number*	*Date Reported to Public Health*	*Nature of Contact*
Name	*Age*	*City, State*	*Onset Date*	*Relationship*
	Sex	*Telephone Number*	*Date Reported to Public Health*	*Nature of Contact*

Comments / Remarks:

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Exposures / Risk Factors

Provide information about the patient's wound and drug use in the table below.

	Yes	No	Unk	*If yes, specify as noted*
Wound or Abscess	☐	☐	☐	Location(s): Description: Date of injury: ___ ___ ____ How wound occurred: Did/does wound appear infected? ☐Yes ☐No ☐Unk
Injects Black Tar Heroin (Chiba)	☐	☐	☐	Date last used: ___ ___ ____ Injection method (check all that apply): ☐Intravenous ☐Intramuscular ☐Subcutaneous (skin-pop) ☐Other: _____ ☐Unk
Injects other drugs	☐	☐	☐	Drugs injected (check all that apply): ☐Heroin ☐Cocaine ☐Methamphetamine ☐Other: _____ ☐Unk Injection method (check all that apply): ☐Intravenous ☐Intramuscular ☐Subcutaneous (skin-pop) ☐Other: _____ ☐Unk
Sniffs/snorts drugs	☐	☐	☐	Drugs sniffed/snorted (check all that apply): ☐Heroin ☐Cocaine ☐Methamphetamine ☐Other: _____ ☐Unk
Uses other drugs	☐	☐	☐	Types:

Provide information regarding any suspect food items consumed prior to illness in the table below. If more than three items, append pages; please ask about high risk foods even if wound botulism is suspected. Please pay special attention to fish or seafood exposures.

	Suspect Food 1	*Suspect Food 2*	*Suspect Food 3*
Food item			
Date and time eaten	Date:___ ___ ___ Time:___ ___am/pm	Date:___ ___ ___ Time:___ ___am/pm	Date:___ ___ ___ Time:___ ___am/pm
Type of item (check one)	☐Homemade ☐Commercial product • Brand: _____ • Lot number: _____ ☐Restaurant-associated ☐Unk	☐Homemade ☐Commercial product • Brand: _____ • Lot number: _____ ☐Restaurant-associated ☐Unk	☐Homemade ☐Commercial product • Brand: _____ • Lot number: _____ ☐Restaurant-associated ☐Unk
How item preserved	☐Canned ☐Dried ☐Fermented ☐Salted ☐Pickled ☐No preservation ☐Other: _____ ☐Unk	☐Canned ☐Dried ☐Fermented ☐Salted ☐Pickled ☐No preservation ☐Other: _____ ☐Unk	☐Canned ☐Dried ☐Fermented ☐Salted ☐Pickled ☐No preservation ☐Other: _____ ☐Unk
How item stored	☐Unrefrigerated ☐Refrigerated ☐Frozen ☐Unk ☐Other:_____	☐Unrefrigerated ☐Refrigerated ☐Frozen ☐Unk ☐Other:_____	☐Unrefrigerated ☐Refrigerated ☐Frozen ☐Unk ☐Other:_____
How item served	☐Heated ☐Only warmed ☐Unheated ☐Fried ☐Boiled ☐Other: _____ ☐Unk	☐Heated ☐Only warmed ☐Unheated ☐Fried ☐Boiled ☐Other: _____ ☐Unk	☐Heated ☐Only warmed ☐Unheated ☐Fried ☐Boiled ☐Other: _____ ☐Unk
# persons sharing item			
# persons ill			
Samples of food available	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Samples submitted for botulism testing	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk
Foods of same lot/batch recovered or recalled	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk	☐Yes ☐No ☐Unk

Provide information regarding any other exposures of interest in the table below.

Exposure	*Description*

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Clinical Outcome Report*

Please include copy of discharge summary

Please complete upon discharge or death and fax to 404-639-2205 ATTN: Botulism Surveillance

REPORTING AGENCY

Treating Physician - Last Name, First Name	*Telephone Number*	*Fax Number*	*Today'sDate* ___ ___ _____
Attending Physician Name - Last Name, First Name	*Telephone Number*	*Fax Number*	*Speciality*
Hospital Name	*City*	*State*	*Zip Code*

DEMOGRAPHIC INFORMATION

Patient Name - Last Name, First Name, Middle Initial	*City*	*State*	*Zip Code*

Date of Birth ___ ___ _____	*Sex* □Male □Female

CLINICAL OUTCOME INFORMATION

How many days was patient hospitalized? _____days

How many days was patient in intensive care? _____days

Did patient require mechanical ventilation? □Yes □No □Unk

If yes, how many days was patient on a ventilator? _____days

Did patient require a a tracheostomy? □Yes □No □Unk

If yes, when was the tracheostomy done? ___ ___ _____

Did the patient develop pneumonia? □Yes □No □Unk

What was the final diagnosis? (*please check one)*

□Botulism □Tick paralysis □Paralytic shellfish poisoning
□Myasthenia gravis □Eaton-Lambert syndrome □Other_____
□Guillain-Barre syndrome □Stroke or central nervous system mass or lesion

Was treatment given for any of the above diagnosis (even if it wasn't the final diagnosis)? □Yes □No □Unk

If yes, specify type
□Botulism Antitoxin □Plasmapheresis □Neostigmine/Physostigmine □Other Immunoglobulin therapy_____

Did the patient develop an adverse event after botulism antitoxin administration? □Yes □No □Unk

If yes, specify adverse event _____

Did the patient die? □Yes □No □Unk

If yes,

When did patient die? ___ ___ _____

What was the cause of death? _____

If no,

Where was patient discharged?
□Home □Nursing home □ Physical therapy/rehabilitation facility □Other (specify)_____

Did patient have residual disability upon discharge? □Yes □No □Unk

If yes, please specify types below (check as many as apply)

□Proximal Upper Extremity Weakness □Diminshed deep tendon reflexes □Other_____
□Distal Upper Extremity Weakness □Fatigue □Other_____
□Proximal Lower Extremity Weakness □Stroke or central nervous system mass or lesion
□Distal Lower Extremity Weakness □Other_____

ADDITIONAL INFORMATION

Comments / Remarks: