



Campylobacteriosis Case Report Form

Please fill this form out as completely as possible. This form includes all the necessary information from both the FoodNet Case Report Form and *Campylobacter* Disease-Specific Form.
Any information not available for NBS data entry may be useful in your investigation.

Last Name: _____ First: _____ Middle: _____ DOB: _____
PSN1 _____ TN01 CAS1 _____ TN01 State Lab Accession #: _____

FOR ADMINISTRATIVE USE

FoodNet Case? Yes No Unknown
Was the case found during an audit*? Yes No Unknown
Was the case interviewed by public health? Yes No Unknown
If no, was an attempt made? Yes No Unknown
Was an exposure history obtained? Yes No Unknown

*Our FoodNet hospital visit constitutes an audit.

Date of interview completion: _____
Date of first interview attempt: _____
Interviewer's Name: _____

DEMOGRAPHICS

Reported Age: _____ Days Months Years Sex: Male Female Unknown
Ethnicity: Hispanic Not Hispanic Race: American Indian / Alaskan Hawaiian / Pacific Islander Asian White Black / African American Other: _____ Refused to answer

Street Address: _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Did the patient immigrate to the US within 7 days of specimen collection? Yes No Unknown
In the past 7 days have you lived/stayed overnight in any of the following locations? (check all that apply)
 Dormitory Long-term Care Facility/Rehab Center Homeless Shelter Outdoors/Other structure not intended for housing Unknown
 Correctional Facility Other communal living: _____ None of the above

Employer/School: _____ Occupation: _____

Is this patient associated with a daycare facility? Yes No Unknown
If yes, specify the association: (check all that apply) Attend daycare Work/volunteer at daycare Live with daycare attendee
If yes, daycare name: _____

Is this patient a food handler? Yes No Unknown If yes, establishment name: _____

LAB REPORT

Reporting Facility: _____ Ordering Facility: _____
Ordering Provider: _____ Phone Number: _____

Jurisdiction: East Tennessee West Tennessee Jackson/Madison Mid-Cumberland Upper Cumberland Memphis/Shelby Northeast Nashville/Davidson Sullivan South Central Chattanooga/Hamilton Out of Tennessee Southeast Knoxville/Knox Unassigned

Lab Report Date: _____
Date Received by Public Health: _____
Date Specimen Collected: _____

Specimen Source: Blood Stool Urine Unknown Other: _____
Test Type: PCR EIA Culture Other: _____

INVESTIGATION

Investigation Start Date: _____
Investigator: _____
Date Assigned to Investigation: _____

Case Status: Confirmed Probable Suspect
Investigation Status: Open Closed

SYMPTOM HISTORY

Date of Illness Onset: _____ First Symptom: _____
Symptoms: Diarrhea Bloody diarrhea Constipation Vomiting Nausea Fever (Max) _____ °F
(Check all that apply) Fatigue Chills Abdominal cramps Muscle aches Weight loss Headache
 Other: _____

If yes to diarrhea, date of diarrhea onset: _____

If yes to vomiting, date of vomiting onset: _____

As of today, are you still experiencing symptoms? Yes No Unknown Duration of illness: _____ Minutes Hours Days

If recovered, date of recovery: _____

CLINICAL INFORMATION / HOSPITALIZATION

Was the patient hospitalized for this illness?

Yes No Unknown

If yes, Hospital Name: _____

Admission Date: _____

Discharge Date: _____

Was the patient transferred from one hospital to another?

Yes No Unknown

If yes, specify the hospital to which the patient was transferred:

Was there a second hospitalization?

Yes No Unknown

If yes, Hospital Name: _____

Admission Date: _____

Discharge Date: _____

During any part of the hospitalization, did you stay in an Intensive Care Unit (ICU) or a Critical Care Unit (CCU)?

Yes No Unknown

Is the patient pregnant? Yes No Unknown

Did the patient die from this illness? Yes No Unknown

MEDICATION / HEALTH HISTORY

To better understand your illness and the factors that may affect illness, we ask a few general questions about medications and health history.

Did you take any antibiotics for this illness?

Yes No May Have Did Not Ask/Answer

If yes, what antibiotics did you take? (i.e. Amoxicillin, Bactrim, Clindamycin, Z-Pak)

In the 30 days before your illness began...

Did you take any antibiotics?

Yes No May Have Did Not Ask/Answer

If yes, what antibiotics did you take? (i.e. Amoxicillin, Bactrim, Clindamycin, Z-Pak)

Did you have any form of antacid?

Yes No May Have Did Not Ask/Answer

Antacids are medications to block acid, often for heartburn, indigestion or acid reflux.

If yes, what medications to block acids did you take? (i.e. Tums, Pepto, Prilosec)

Did you take a probiotic?

Yes No May Have Did Not Ask/Answer

Probiotics are live microorganisms (such as certain types of bacteria) that may benefit your health. These can be pills, powders, yogurts, and other fermented dairy products, as well as anything labeled as containing "live and active cultures" or "probiotics."

In the 6 months before your illness began...

Did you have abdominal surgery? (i.e. removal of appendix or surgery of the stomach or large intestine, not including C-section)

Yes No May Have Did Not Ask/Answer

Were you diagnosed or treated for cancer? (including leukemia/lymphoma)

Yes No May Have Did Not Ask/Answer

Are you diabetic? (not including gestational diabetes)

Yes No Unknown Did Not Ask/Answer

TRAVEL HISTORY

Did you travel in the 7 days prior to onset of illness? Yes No Unknown

Destination	Date of Arrival	Date of Departure	Notes

In the 6 months before illness, did you travel outside the United States? Yes No May Have Did Not Ask/Answer

If yes, what countries did you visit? _____

In the 6 months before illness, did any members of your household travel outside the United States?

Yes No May Have Did Not Ask/Answer

If yes, what countries did your household members visit? _____

RELATED CASES

Does the patient know of any similarly ill persons (with diarrhea)? Yes No Unknown

Are there any other cases related to this one? Yes, household Yes, outbreak No, sporadic Unknown

If yes, please provide names, onset dates, contact information and any other details for similarly ill persons or related cases:

OUTBREAK/CLUSTER

Is this case part of an outbreak? Yes No Unknown

CDC cluster code: _____

Type of outbreak:

CDC NORS number: _____

- Animal contact Foodborne Person-to-person Environmental contamination (not food or water) Waterborne
 Unknown Other Indeterminate

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

These questions are about exposures you may have had in the 7 days before you got sick. There are questions about various items, including animals, ill persons, water, special diets, special events, and various foods you may have come into contact with. For each of the questions, please answer yes, no, or may have.

ANIMAL CONTACT — In the 7 days before illness...

1. Did you **work** at, **live** on, or **visit** a farm, ranch or petting zoo with animals? (circle which setting)
 1A. Where? _____ When? _____

2. Did you come into contact with any...	Yes	No	May Have	Did Not Ask/Answer		Yes	No	May Have	Did Not Ask/Answer
Cats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rodents/small mammals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dogs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reptile/amphibian?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken/turkey?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cattle/goat/sheep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birds (non-poultry)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pig?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____									

2A. Where did you come into contact with the animal(s)? _____ When? _____

3. Did you come into any contact with animal feces or manure? Yes No May Have Did Not Ask/Answer

4. Did you come into contact with a pet that had diarrhea? Yes No May Have Did Not Ask/Answer

5. Did you have any contact with dry, canned, or frozen animal feed?
 5A. Please describe: _____

PERSON-TO-PERSON

1. Did one of your household members or another person you spend a lot of time with have diarrhea in the 7 days before you became ill?
 1A. Who? _____ Where? _____

WATER

1. Do you use water from a private well as your primary source of drinking water? Yes No May Have Did Not Ask/Answer

2. Did you drink any water directly from a natural spring, lake, pond, stream, or river in the 7 days before illness? Yes No May Have Did Not Ask/Answer

3. Did you swim or wade in water from a natural setting (lake, river, pond, ocean, etc.) in the 7 days before illness? Yes No May Have Did Not Ask/Answer

4. Did you swim or wade in treated/chlorinated water (pool, hot tub, waterpark, fountain, etc.) 7 days before illness? Yes No May Have Did Not Ask/Answer

FOOD PREFERENCES

1. Are you a vegetarian or vegan? Yes No May Have Did Not Ask/Answer

2. Before you became ill, were you on a special diet for medical, weight loss, religious, allergies or any other reason?
 2A. Please describe: _____

EVENTS/ RESTAURANTS — In the 7 days before illness...

1. Did you attend any special events (concerts, festivals, sporting events, meetings, religious gatherings, etc.)?
 1A. What event(s)? _____ Where? _____ When? _____

2. Did you eat food prepared outside the home (restaurants, catered events, etc.)? Yes No May Have Did Not Ask/Answer

- 2A. If **yes** or **maybe** ate out, which setting? (check all that apply)
- Fast-food (order at counter) Take-out or delivery food Bakery Other: _____
 Sit-down restaurant (order taken at table) Catered event Ice cream or dessert shop
 Self-serve buffet School or other institutional setting Coffee or tea shop

2B. Name(s) and Address(es): _____ Foods eaten: _____ When? _____

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These next questions are about where your food at home came from in the 7 days before you became ill.

SOURCES OF FOOD AT HOME

<i>Did your food come from...</i>	Yes	No	May Have	Did Not Ask/Answer	Name(s) and Location(s)
1. Grocery stores/supermarkets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Warehouse stores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Small markets/mini-marts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Health food, "whole food" stores, co-ops?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Farmer's markets, roadside stands, farm? (including farm shares, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

The next section is about specific foods you may have eaten, grouped by category. For each food item, please answer yes, no, or may have eaten. The first category is meats, which includes whole meats or meats on a salad, sandwich, or in a prepared dish, etc.

<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
MEAT/POULTRY						
*1. Any chicken or foods containing chicken?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*1A. Fresh chicken prepared at home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*1B. Frozen chicken prepared at home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*1C. Ground chicken prepared at home or outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*1D. Chicken outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*2. Any turkey or foods containing turkey? (including deli meat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*2A. Ground turkey at home or outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*2B. Turkey outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*3. Did you or anyone in your household handle raw poultry?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*4. Any beef or foods containing beef?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*4A. Ground beef at home or outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*4B. Undercooked or raw ground beef at home or outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*4C. Beef outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*4D. Any veal at home or outside the home ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*5. Did you or anyone in your household handle raw beef ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*6. Any pork or foods containing pork? (including deli meat, sausage, bacon, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*7. Any lamb or mutton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*8. Any liver paté?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*8A. Raw or undercooked liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*9. Any fish or fish products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*9A. Raw or undercooked fish? (sushi, sashimi, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*10. Any seafood ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*10A. Raw or undercooked seafood? (crab, shrimp, oyster, clam, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*11. Did you or anyone in your household handle raw fish or seafood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

These next questions are about eggs and dairy products.

<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
EGGS						
*1. Any eggs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*1A. Eggs that were raw, soft-boiled, "runny", or "over-easy"?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*2. Any foods made with raw eggs? (cookie dough, homemade mayo, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*3. Eggs outside the home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

DAIRY						
*1. Pasteurized cow's or goat's milk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*2. Raw or unpasteurized milk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Yogurt?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Ice cream?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Cheese? (block, shredded, sliced, string cheese, cottage cheese, feta, parmesan, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*6. Soft cheese? (queso fresco, brie, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*7. Soft cheese made from raw milk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8. Other raw milk cheeses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*9. Other unpasteurized dairy products? (yogurt, ice cream, etc. made from raw milk)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

These next questions are about fresh fruits. This includes whole fruits as well as cut fruits that may have been part of a salad, sandwich, or smoothie, etc. This does not include fruits that are canned or cooked.

<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
FRUITS						
*1. Berries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1A. Strawberries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1B. Raspberries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1C. Blueberries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1D. Other berries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*2. Cantaloupe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*3. Watermelon?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Other fruits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*5. Any raw or unpasteurized juice or cider? (sometimes bought from a farm or orchard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

*These next questions are about **fresh, raw** vegetables unless otherwise specified. This includes vegetables that are whole, cut/chopped, or a component of another food item.*

<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
VEGETABLES						
*1. Lettuce?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*2. Spinach?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*3. Sprouts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Other greens?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*5. Tomatoes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Other fresh vegetables?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
*7. Any fresh (not dried) herbs? (basil, cilantro, parsley, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

These next questions are about other foods that have not been asked about yet.

Other Foods

<i>In the 7 days before illness did you eat ...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
1. Any foods marketed for babies? (formula, store-bought baby food, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Any powdered shake or meal products?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Other foods that feel relevant that have not already been covered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

This is the end of the food and exposure specific questions.

OTHER COMMENTS

Is there anything else you feel may be relevant that has not already been asked?

FOR INTERVIEWER USE ONLY

At the conclusion of the interview please...

- Answer any questions
- Exclude persons from sensitive populations until 2 negative stools (health care, food handler, day care)
- Thank the patient for their time
- Central Office staff:** contact regional or local health department if patient is from a sensitive population
- Provide hygiene and prevention education
- Notify the appropriate staff of potential outbreaks, events, or unusual information

INTERVIEWER COMMENTS