Reset Form

DEPARTMENT OF
HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30333

TYPHOID AND PARATYPHOID FEVER SURVEILLANCE REPORT

CDC NO.: ☐☐☐☐☐

STATE LAB ISOLATE ID NO. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved:
OMB No. 0920-0009

Instructions:

– Please complete this form only for new, symptomatic, culture-proven cases of typhoid or paratyphoid fever. –

DEMOGRAPHIC DATA

1. Reporting State: ☐☐

2. First three letters of patient's last name: ☐☐☐

3. Date of birth: ☐☐ Mo. ☐☐ Day ☐☐☐☐ Yr. ***or*** Age: (in years) ☐☐

4. Sex: ☐ Male ☐ Female

5. Does the patient work as a foodhandler? ☐ Yes ☐ No ☐ Unk.

6. Citizenship: ☐ U.S. ☐ Other: _____ ☐ Unk.

CLINICAL DATA

7. Was the patient ill with typhoid or paratyphoid fever? (fever, abdominal pain, headache, etc) ☐ Yes ☐ No ☐ Unk.

If Yes, give date of onset of symptoms: ☐☐ Mo. ☐☐ Day ☐☐ Yr.

8. Was the patient hospitalized? ☐ Yes ☐ No ☐ Unk.

If Yes, how many days was the patient hospitalized? ☐☐ Days

9. Outcome of case: ☐ Recovered ☐ Died ☐ Unk.

LABORATORY DATA

10. Date *Salmonella* first isolated: ☐☐ Mo. ☐☐ Day ☐☐ Yr.

Site(s) of isolation: *(check all that apply)*

☐ Blood ☐ Stool ☐ Gall Bladder ☐ Other (specify): _____

Serotype:

☐ Typhi ☐ Paratyphi A ☐ Paratyphi B ☐ Paratyphi C

11. Was **antibiotic sensitivity testing** performed on this (these) isolate(s) at the laboratory? *(Please contact the clinical laboratory for this information)* ☐ Yes ☐ No ☐ Unk.

If Yes, was the organism resistant to:

- Ampicillin: ☐ Yes ☐ No ☐ Not tested
- Chloramphenicol: ☐ Yes ☐ No ☐ Not tested
- Trimethoprim-sulfamethoxazole: ☐ Yes ☐ No ☐ Not tested
- Fluoroquinolones (e.g., Ciprofloxacin): ☐ Yes ☐ No ☐ Not tested

EPIDEMIOLOGIC DATA

12. Did this case occur as part of an outbreak? *(two or more cases of typhoid or paratyphoid fever associated by time and place)* ☐ Yes ☐ No ☐ Unk.

13. Did the patient receive typhoid vaccination (primary series or booster) within **five years** before onset of illness? ☐ Yes ☐ No ☐ Unk.

If Yes, indicate type of vaccine received:

- Oral Ty21a or Vivotif (Berna) four pill series: ☐ Yes ☐ No ☐ Unk. Year received ☐☐
- ViCPS or Typhim Vi shot (Pasteur Merieux): ☐ Yes ☐ No ☐ Unk. ☐☐

14. Did the patient travel or live outside the United States during the 30 days before the illness began? ☐ Yes ☐ No ☐ Unk.

If Yes, please list in order the countries visited during the 30 days before the illness began: (other than the United States)

1. _____ 3. _____
2. _____ 4. _____

Date of most recent return or entry to the United States: ☐☐ Mo. ☐☐ Day ☐☐ Yr.

15. Was the purpose of the international travel:

a. Business? ☐ Yes ☐ No ☐ Unk.
b. Tourism? ☐ Yes ☐ No ☐ Unk.
c. Visiting relatives or friends? ☐ Yes ☐ No ☐ Unk.
d. Immigration to U.S.? ☐ Yes ☐ No ☐ Unk.
e. Other? ☐ Yes ☐ No ☐ Unk.
(if other, specify): _____

16. Was the case traced to a typhoid or paratyphoid carrier? ☐ Yes ☐ No ☐ Unk.

If Yes, was the carrier previously known to the health department? ☐ Yes ☐ No ☐ Unk.

17. Comments:

18. Name of Person Completing Form: _____

Address: _____

Telephone: _____ **Date:** 11/08/2017 Mo. Day Yr.

– THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM –

Please send a copy to your STATE EPIDEMIOLOGY OFFICE and the
Enteric Diseases Epidemiology Branch, Centers for Disease Control and Prevention
Mailstop C-09, Atlanta, Georgia 30333 • Fax: (404) 639-2205

Print Save Form

FoodNet Case Report Form

TN Department of Health

The FoodNet Case Report Form should be used for **Campylobacter, Cryptosporidium, Cyclospora, Listeria, Shigella, STEC, Vibrio and Yersinia**. Please fill this form out as complete as possible.
Do no forget to complete the appropriate disease-specific supplemental form.

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 **FoodNet hospital visits constitutes an audit.**

Was the case interviewed by public health? □ Yes □ No □ Unknown **Date of first attempt:** ____/____/_____

If no, was an attempt made? □ Yes □ No □ Unknown **Date of Interview:** ____/____/_____

Interviewer's Name: _____

Was an exposure history obtained? □ Yes □ No □ Unknown

Demographics

Reported Age: _____ □ Days □ Months □ Years **Sex:** □ Male □ Female □ Unknown

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Did patient immigrate to the US within 7 days of specimen collection? □ Yes □ No □ Unknown

Ethnicity: □ Hispanic □ Not Hispanic

Race: □ American Indian / Alaskan □ Asian □ Black / African American □ Hawaiian / Pacific Islander □ White □ Refused □ Other: _____

Employer/School/Daycare: _____ **Occupation:** _____

Is this patient associated with a daycare facility? □ Yes □ No □ Unknown

If yes, specify association: □ Attend daycare □ Work/volunteer at daycare □ Live with daycare attendee

If yes, name of daycare: _____

Is this patient a food handler? □ Yes □ No □ Unknown

If yes, name of restaurant/facility: _____

Lab Report

Reporting Facility: _____ **Ordering Facility:** _____

Ordering Provider: _____ **Phone Number:** _____

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

Specimen Source: □ Blood □ CSF □ Stool □ Urine □ Unknown □ Other _____

Lab Report Date: ____/____/_____

Date Received by Public Health: ____/____/_____

Date Specimen Collected: ____/____/_____

Organism Identified

□ Campylobacter □ Cryptosporidium □ Cyclospora □ Listeria □ Shigella □ STEC □ Vibrio □ Yersinia

Test Type(s)

□ Culture □ PCR □ EIA □ Other:

Case Status

□ Confirmed □ Probable □ Suspect

Outbreak/Cluster

Is this case part of an outbreak? □ Yes □ No □ Unknown **CDC Cluster Code:** _____

Type of Outbreak: **CDC EFORS/NORS Number:** _____

□ Animal Contact □ Environmental Contamination Other than Food/Water □ Foodborne □ Indeterminate □ Person-to-Person □ Waterborne □ Other: _____

Revised 12/2017

INVESTIGATION

Investigation Start Date: ____/____/_____ **Investigator:** _____

Investigation Status: □ Open □ Closed **Date Assigned to Investigation:** ____/____/_____

SYMPTOM HISTORY

Date/Time of Illness Onset: ____/____/_____ ____:____ □ AM □ PM **First Symptom:** _____

Symptoms: Check all that apply

□ Diarrhea □ Bloody Diarrhea □ Constipation
□ Vomiting □ Nausea □ Weight Loss
□ Fatigue □ Chills □ Fever (Max Temp: _____°F)
□ Headache □ Abdominal Cramps □ Muscle Aches
□ Other: _____

If yes to diarrhea, date/time of diarrhea onset: ____/____/_____ ____:____ □ AM □ PM

If yes to vomiting, date/time of vomiting onset: ____/____/_____ ____:____ □ AM □ PM

As of today, are you still experiencing symptoms? □ Yes □ No □ Unknown

If recovered, date/time of recovery: ____/____/_____ ____:____ □ AM □ PM

Duration of Illness: _____ □ Minutes □ Hours □ Days

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 the patient stay in and 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

TRAVEL HISTORY

Did the patient travel prior to the onset of illness? □ Yes □ No □ Unknown

Type	Destination	Date of Arrival	Date of Departure
□ Domestic □ International			
□ Domestic □ International			
□ Domestic □ International			

Notes:

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, did the health department collect contact information about other similarly ill persons to investigate further?
□ Yes □ No □ Unknown

Provide names, onset dates, contact information and any other details for similarly ill persons or related cases: