

SHIGELLOSIS CASE INVESTIGATION FORM

Use this form to interview confirmed and probable cases of shigellosis.

Questions marked with * are required in FoodNet counties (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson) and must be entered into CEDRS

Patient Name: _____ CEDRS # _____ Interview date: ___/___/___
Agency Name: _____ Form Completed by: _____
Person interviewed: Case Other (circle: Parent Spouse Household member Friend)

Demographics and Contact Information

*Date of Birth ___/___/___ Age: _____ (Circle: Yrs., Mos., Days) *Sex: F M

*Race (Circle all that apply):

American Indian/Alaska Native Asian Black Unknown
Pacific Islander/Hawaiian Native White Other

*Ethnicity (Circle one): Hispanic Non Hispanic Unknown

Language spoken: _____ Parent/legal guardian: _____

Residence:

Address: _____
City: _____
County: _____
Zip Code: _____

Phone Numbers:

Home Phone: (____) _____
Work Phone: (____) _____
Pager: (____) _____
Mobile: (____) _____

Laboratory information *****please confirm lab information with patient, even if already in CEDRS

Culture confirmed: Yes No Serogroup (circle): sonnei flexneri boydii dysenteriae unknown
Lab or hospital name: _____

*Date specimen(s) collected: ___/___/___ *Specimen source: Stool Urine
Blood Other: _____

Physician Name: _____ MD Phone: (____) _____

Clinic Name: _____ City/State: _____

Clinical Description (Yes=Y; No=N; Unknown=U)

Did the patient have symptoms?: Y N U If yes, *onset date ___/___/___ Time: ___ AM / PM

Did the patient have:

Diarrhea Y N U Fever (max temp_____) Y N U Headache Y N U
Date diarrhea onset ___/___/___ Vomiting Y N U Body aches Y N U
Bloody diarrhea Y N U Abd. cramps Y N U Other_____ Y N U

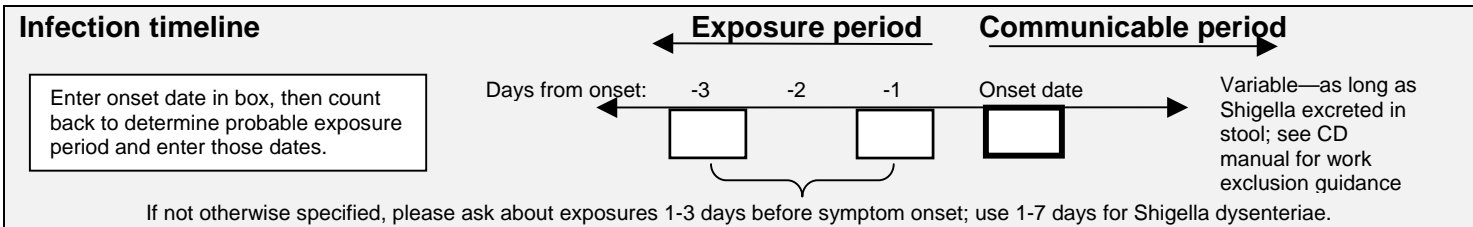
How many days did the illness last? _____ days

Did case receive antibiotics for this illness? Y N U Antibiotic name: _____

*Outcome: Survived Died Unk (FoodNet counties: record pt outcome on 7th day after specimen collect date)
If died, date of death: ___/___/___

*Was patient hospitalized? Yes No Unk (ER visits only not considered "hospitalized")

If hospitalized: *Hospital Name: _____
*Date of Admission: ___/___/___ *Date of Discharge: ___/___/___
*Transferred to another hospital? Yes No Unk *Transfer hosp name: _____



Travel information

*Did patient travel outside the US in the 7 days prior to the onset of illness? Yes No Unk

If yes, Country Date left US Date returned to US

(1) _____

(2) _____

(3) _____

Check box if case was adopted or immigrated to US (no "date left US")

Did patient travel within the US in the 7 days prior to the onset of illness? Yes No Unk

If yes, where/when: _____

Water (ask about preceding 1-3 days, unless patient has *S. dysenteriae*)

Did patient drink any untreated water from a pond, stream, spring, or lake? Yes No Unk

Did the patient swim or wade in any of the following types of recreational water? If yes, location / dates:

Hot tub/spa, whirlpool, Jacuzzi	Y	N	U	
Lake, pond, river, or stream	Y	N	U	
Recreational water park or any type of fountain	Y	N	U	
Swimming or wading pool	Y	N	U	
Drainage ditch/irrigation canal	Y	N	U	
Other, specify: _____				

Restaurant history/Group activities

Any restaurants, group gatherings, picnics, or sporting events during the 1-3 days before illness? Yes No Unk

If yes, Name Address Date of Exposure Foods Eaten

Did others accompanying the case become ill with diarrhea, fever, or abdominal pain? Yes No Unk

(If others became ill after a common exposure, this may be an outbreak. Call regional epidemiologist or CDPHE for assistance)

Grocery / food store history

List the food store(s) or grocery store(s) for foods consumed during 1-3 days prior to illness:

Name/location: _____

Name/location: _____

Did patient purchase/consume any food from a farmer's market? Yes No Unk If yes, what/where? _____

Did patient purchase/consume any food from a specialty stores? Yes No Unk If yes, what/where? _____

(such as a carniceria, or ethnic market)

Food history Interviewer: if patient is unsure, ask patient if it is likely if s/he ate a particular food item

During 1-3 days prior to onset of illness:

Provide details including where food purchased, when consumed, etc, below:

Meats/Fish

Raw oysters Y N U
 Other raw or partially cooked seafood / fish? Y N U
 Dried meats (salami, jerky, etc) Y N U

Produce

Any food from a salad bar Y N U
 Sprouts (bean, alfalfa, clover...) Y N U
 Uncooked tomatoes Y N U
 Lettuce Y N U
 Prepared at home Y N U
 Lettuce purchased as (check all that apply):
 Precut/pre-shredded Head
 Prepared elsewhere Y N U

Where:

Uncooked green onions (scallions) Y N U
 Uncooked cilantro Y N U
 Other raw vegetables: _____ Y N U

Any juice or cider that was NOT pasteurized Y N U
 Cantaloupe Y N U
 Honeydew Y N U
 Other fruits: _____ Y N U

Other Food Items.

Foods brought from another country Y N U
 Fresh salsa / pico de gallo Y N U
 Health food products or supplements Y N U
 Infant food or formula Y N U

School/Work

Occupation: _____
 Place of Employment: _____

Student? Yes No
 If yes, Name of School: _____

During incubation period, did the case work/volunteer/attend a child care setting? Yes No Unk

Since the case became ill, has the case attended, worked or volunteered at a child care center / preschool? Yes No Unk

Does the case...(circle appropriate answer):

Have a child(ren) in a child care center? Yes No Unk

Attend, work or volunteer at a residential facility? (e.g. nsg home) Yes No Unk

If yes to any of the above,

Name and location of facility _____

Are other children/staff ill? Yes No Unk

Provide direct patient care as a health care worker? Yes No Unk

If yes, name and location of facility _____

Work as a food handler? Yes No Unk

If yes, name and location of facility _____

Since the case became ill, did case prepare food for any public or private gatherings? Yes No Unk

If yes, provide details: _____

Contact with others (during 1-3 days prior to illness)

Did patient have contact with any individual who had a diarrheal illness? Yes No Unk

If yes, which of the following describes the individuals (check all that apply):

- Child
- Child attending child care
- Child attending school
- Household member, not sexual partner
- Household member and sexual partner
- Male sexual partner
- Female sexual partner
- Other (specify) _____

Contact management

Complete the table below for **all** household members and other close contacts. If any of these persons has been ill with similar symptoms, please indicate the date of onset and symptoms.

Name	Age	Occupation/ Child Care	Similar illness	Onset m d y	Comments
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____

Epi-links

Is any person listed above already a confirmed or suspected case in CEDRS? Yes No Unk *If yes, CEDRS#* _____

Is this patient part of a known/suspected outbreak? Yes No Unk *If yes, specify:* _____

If case or household contact or case is high risk (food handler, health care worker, child care) refer to CD manual for restrictions/follow up. Obtain details of site, job description, dates worked/attended during communicable period, supervisor name, etc.

Notes:

Summary of follow up

- Hygiene education provided
- Work or childcare restriction for case
- Follow up of other household members
- Child care center inspected
- Restaurant inspected
- _____

Questions about filling out this form?

Contact the Communicable Disease Epidemiology Program at 303-692-2700, 800-866-2759

After finishing case interview, update the CEDRS record. Do NOT send this form to CDPHE unless it is requested (e.g. as part of a suspected outbreak).