

**North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch**



ATTENTION HEALTH CARE PROVIDERS:

Please report relevant clinical findings about this disease event to the local health department.

Durham County Health Department
Communicable Disease Control
414 East Main Street
Durham, NC 27701

Telephone: (919) 560-7600
Fax: (919) 560-7716

**BOTULISM, FOODBORNE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 10**

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name— City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? Y N U
 If yes, symptom onset date (mm/dd/yyyy): ___/___/___

CHECK ALL THAT APPLY:

Fatigue or malaise or weakness Y N U
 Cranial nerve or bulbar weakness or paralysis Y N U
 Onset date (mm/dd/yyyy): ___/___/___
 Please specify (select all that apply)
 Head drooping
 Blurred vision or double vision
 Drooping eyelids / ptosis
 Difficulty swallowing (dysphagia)
 Difficulty speaking (dysarthria)
 Loss of facial expression
 Other _____

Muscle weakness (paresis) Y N U
 Please specify Localized Generalized

Muscle paralysis Y N U
 Acute flaccid paralysis Y N U
 Onset date (mm/dd/yyyy): ___/___/___
 Asymmetric Symmetric

Respiratory paralysis Y N U
 Onset date (mm/dd/yyyy): ___/___/___

EMG performed Y N U
 Date performed (mm/dd/yyyy): ___/___/___
 Result _____

Nerve conduction study performed Y N U
 Date performed (mm/dd/yyyy): ___/___/___
 Result _____

Head CT performed Y N U
 Date performed (mm/dd/yyyy): ___/___/___
 Result _____

MRI performed Y N U
 Date performed (mm/dd/yyyy): ___/___/___
 Result _____

Tensilon test performed Y N U
 Result _____

Dry mouth Y N U
 Shortness of breath/difficulty breathing/
 respiratory distress Y N U
 Vomiting Y N U
 Diarrhea Y N U
 Maximum number of stools in a 24-hour period: _____
 Constipation Y N U
 Dizziness (vertigo) Y N U
 Abdominal swelling Y N U
 Other symptoms, signs, clinical findings, or complications consistent with this illness Y N U
 Please specify: _____

PREDISPOSING CONDITIONS
 Any immunosuppressive conditions? Y N U
 Specify _____

REASON FOR TESTING
 Why was the patient tested for this condition?
 Symptomatic of disease
 Screening of asymptomatic person with reported risk factor(s)
 Exposed to organism causing this disease (asymptomatic)
 Household contact to a person reported with this disease
 Other, specify: _____
 Unknown

HOSPITALIZATION INFORMATION
 Was patient hospitalized for this illness >24 hours? Y N U
 Hospital name: _____
 City, State: _____
 Hospital contact name: _____
 Telephone: (____) _____
 Admit date (mm/dd/yyyy): ___/___/___
 Discharge date (mm/dd/yyyy): ___/___/___

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
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ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? Y N U
 If yes, specify: _____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? Y N U
 Died? Y N U
 Died from this illness? Y N U
 Date of death (mm/dd/yyyy): ____/____/____

TREATMENT

Was botulism antitoxin given? Y N U
 Date antitoxin given (mm/dd/yyyy): ____/____/____
 Time treatment began _____ AM PM
 Did the patient require mechanical ventilation? Y N U
 If yes, give details: _____

TRAVEL/IMMIGRATION

The patient is:
 Resident of NC
 Resident of another state or US territory
 Foreign Visitor
 Refugee
 Recent Immigrant
 Foreign Adoptee
 None of the above

Did patient have a travel history during the 48 hours prior to onset of symptoms? Y N U
 List travel dates and destinations:
 From ____/____/____ to ____/____/____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? Y N U
 List persons and contact information:

Additional travel/residency information:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? Y N U
 Patient a child care worker or volunteer in child care? Y N U
 Patient a parent or primary caregiver of a child in child care? Y N U
 Is patient a student? Y N U
 Type of school: _____
 Is patient a school WORKER / VOLUNTEER in NC school setting? Y N U
 Give details: _____

BEHAVIORAL RISK & CONGREGATE LIVING

During the 48 hours prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? Y N U
 Name of facility: _____
 Dates of contact: from ____/____/____ until ____/____/____

During the 48 hours prior to onset of symptoms, did the patient attend social gatherings or crowded settings? Y N U
 If yes, specify: _____

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient Department	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

During the 48 hours prior to onset of symptoms, did the patient use injection drugs not prescribed by a doctor? Y N U
 Specify drug(s): _____

During the 48 hours prior to onset of symptoms, did the patient use NON-injection street drugs? Y N U

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 If yes, specify: _____

FOOD RISK AND EXPOSURE

Where does the patient/patient's family typically buy groceries?
 Store name: _____
 Store city: _____
 Shopping center name/address: _____

During the 48 hours prior to onset of symptoms, did the patient:
 Eat any food items that came from a produce stand, flea market, or farmer's market? ... Y N U
 Specify source: _____
 Eat any food items that came from a store or vendor where they do not typically shop for groceries? Y N U
 Specify source(s): _____

During the 48 hours prior to onset of symptoms, did the patient do any of the following:
 Drink unpasteurized juices or ciders? Y N U
 Specify juices or ciders:
 Apple
 Orange
 Other, specify: _____

Eat pork/pork products? Y N U
 Specify type of pork/pork product:
 Sausage
 Smoked Unsmoked
 Chops
 Roast
 Ham
 Smoked Cured Canned
 Other, specify: _____

Bacon
 BBQ
 Other, specify: _____

Eat wild game meat (deer, bear, wild boar)? Y N U
 Specify type of wild game meat:
 Deer/venison
 Bear
 Wild boar/javelina/feral hog
 Other, specify: _____

Eat other meat / meat products (i.e. ostrich, emu, horse)? Y N U
 Specify other meat/meat product:
 Ostrich
 Emu
 Horse
 Other, specify: _____

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)? Y N U
 Handle/eat clams? Y N U
 Handle/eat crabs? Y N U
 Handle/eat lobster? Y N U
 Handle/eat mussels? Y N U
 Handle/eat oysters? Y N U
 Handle/eat shrimp? Y N U
 Handle/eat crawfish? Y N U
 Handle/eat other shellfish? Y N U

Handle/eat finfish (i.e. Tuna, Mackerel, Skip Jack, Amber Jack, Bonito, mahi-mahi / dorado, Blue fish, Salmon, Puffer fish, Porcupine fish, Ocean sunfish, sushi)? Y N U
 Specify type of finfish:
 Tuna Puffer fish
 Mackerel Parrot fish
 Skip Jack or Amberjack Porcupine fish
 Bonito Ocean sunfish (Mola mola)
 Mahi-mahi Bluefish
 (dorado/"blue dolphin") Salmon
 Sushi, unknown type of fish
 Other: specify _____
 Unknown

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FOOD RISK AND EXPOSURE (CONTINUED)

During the 48 hours prior to onset of symptoms, did the patient:

Handle/eat other seafood (i.e. octopus, squid) or frogs? Y N U
Specify other seafood:
 Squid Octopus Frog
 Other, specify: _____

Eat raw salads or vegetables other than sprouts? Y N U
Specify raw salad or vegetable:
 Bagged salad greens without toppings, type: _____
 Salad with toppings, specify: _____
 Lettuce, type: _____
 Spinach
 Tomatoes, type: _____
 Cucumbers
 Mushrooms, type: _____
 Onions, type: _____
 Potatoes, type: _____
 Other, specify: _____

Eat sprouts? Y N U
Specify type of sprouts:
 Alfalfa Clover Bean
 Other, specify: _____
 Unknown

Eat fresh herbs? Y N U
Specify:
 Basil Thyme
 Parsley Cilantro
 Oregano Rosemary
 Cumin
 Other, specify: _____

Eat prepackaged, processed meat/meat products (does not include dried, smoked, or preserved products)? Y N U
Specify type of prepackaged, processed meat/meat product:
 Hot dogs
 Cold Cuts
 Bologna
 Turkey
 Ham
 Other cold cut, specify _____
Any other ready-to-eat meat? Specify: _____

Eat ready-to-eat dried, preserved, smoked, or traditionally prepared meat (i.e. summer sausage, salami, jerky)? Y N U
Specify type of prepared meat:
 Summer sausage, specify: _____
 Salami
 Jerky
 Other, specify: _____

Eat deli-sliced (not pre-packaged) **meat?** Y N U
Specify type of meat:
 Bologna
 Turkey
 Ham
 Roast beef
 Chicken
 Other, specify _____

Eat meat stews or meat pies? Y N U
Specify: _____

Eat gravy (i.e. beef, chicken, turkey)? Y N U
Specify: _____

Eat potentially hazardous foods (i.e. pastries, custards, salad dressings)? Y N U
Specify:
 Pastries
 Custards
 Salad dressings
 Other: specify _____

Eat commercially-prepared, refrigerated foods (i.e. dips, salsa, sandwiches)? Y N U
Specify type of food:
 Dips, specify: _____
 Salsa
 Sandwiches, Specify: _____
 Other, Specify: _____

Eat baked potatoes/sweet potatoes? Y N U

Eat preserved, smoked, salted, fermented, or traditionally-prepared fish? Y N U

Eat unviscerated (entrails left in) **fish?** Y N U

Eat vacuum-packed (modified atmosphere packing) **foods?** Y N U

Eat foods stored in oil? Y N U

Eat foods that were processed/canned at home? Y N U

Ingest/consume water or a drink made from water? Y N U

Ingest breast milk? Y N U

Ingest infant formula? Y N U

Eat commercial baby food? Y N U

Ingest honey (i.e. via honey-filled pacifier, honey-water)? Y N U

Ingest molasses? Y N U

Ingest corn syrup? Y N U

Eat a known contaminated food product? Y N U
Specify: _____

Eat at a group meal? Y N U
Specify:
 Place of Worship
 School:
 Social function
 Other, specify:
Name: _____
Location: _____

Eat food from a restaurant? Y N U
Name: _____
Location: _____

Notes:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? Y N U
Date of interview (mm/dd/yyyy): ____/____/____

Were interviews conducted with others? Y N U
Who was interviewed? _____

Were health care providers consulted? Y N U
Who was consulted? _____

Medical records reviewed (including telephone review with provider/office staff)? Y N U
Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?
Specify location:
 In NC
City _____
County _____
 Outside NC, but within US
City _____
State _____
County _____
 Outside US
City _____
Country _____
 Unknown

Is the patient part of an outbreak of this disease? Y N

Notes:

Botulism, foodborne

1996 CDC Case Definition

Clinical description

Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

Laboratory criteria for diagnosis

- Detection of botulinum toxin in serum, stool, or patient's food, or
- Isolation of *Clostridium botulinum* from stool

Case classification

Probable: a clinically compatible case with an epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours)

Confirmed: a clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons who have laboratory-confirmed botulism