

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, INTESTINAL (INFANT)
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 110

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.

Table with 8 columns: 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?
If yes, symptom onset date (mm/dd/yyyy):
CHECK ALL THAT APPLY:
Fatigue or malaise or weakness
Cranial nerve or bulbar weakness or paralysis
Muscle weakness (paresis)
Muscle paralysis
Acute flaccid paralysis
EMG performed
Nerve conduction study performed
Head CT performed

PREDISPOSING CONDITIONS
Any immunosuppressive conditions?
Specify
Gastrointestinal disease
Gastric surgery or gastrectomy

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

ISOLATION/QUARANTINE/CONTROL MEASURES
Did local health director or designee implement additional control measures?
If yes, specify:

CLINICAL OUTCOMES
Discharge/Final diagnosis:
Survived?
Died?
Died from this illness?
Date of death (mm/dd/yyyy):

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

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 30 days 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

Name of care provider: _____
 City: _____ State: _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U

If yes, specify:

BEHAVIORAL RISK & CONGREGATE LIVING

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	<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	

FOOD RISK AND EXPOSURE

During the 30 days prior to onset of symptoms:

Did the patient drink any bottled water? Y N U

Describe the source of drinking water used in the patient's home (check all that apply):
 Bottled water supplied by a company
 Bottled water purchased from a grocery store
 Municipal supply (city water)
 Well water

Did the patient ingest breast milk? Y N U

Source of milk: _____

Did the patient ingest infant formula? Y N U

Type: _____

Did the patient eat commercial baby food? Y N U

Type: _____

During the 30 days 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: _____

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 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 meat stews or meat pies? Y N U

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 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: _____

Eat food from a restaurant? Y N U

Name: _____
 Location: _____

Additional notes, including information about infant formula, infant baby foods, and/or breast milk:

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, infant

1996 CDC Case Definition

Clinical description

An illness of infants, characterized by constipation, poor feeding, and “failure to thrive” that may be followed by progressive weakness, impaired respiration, and death

Laboratory criteria for diagnosis

- Detection of botulinum toxin in stool or serum, or
- Isolation of *Clostridium botulinum* from stool

Case classification

Confirmed: a clinically compatible case that is laboratory-confirmed, occurring in a child aged less than 1 year