

**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, WOUND
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 111**

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 _____

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

Abscess/infected skin lesion (pyoderma) Y N U
 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: _____

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: _____

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? Y N U
 Specify _____

Injury/Wound/Break in skin Y N U
 Recent/Acute injury(ies) or wound(s) Y N U
 Date (mm/dd/yyyy): ___/___/___
 Anatomic site _____
 Was medical care obtained for this injury? Y N U
 Contaminated Y N U

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 / close contact to a person reported with this disease
 Other, specify _____
 Unknown

ISOLATION/QUARANTINE/CONTROL MEASURES

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

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

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): ____/____/____

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): ____/____/____

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 14 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:

BEHAVIORAL RISK & CONGREGATE LIVING

In what setting was the patient most likely exposed?

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

OTHER EXPOSURE INFORMATION

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

If yes, specify:

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, wound

1996 CDC Case Definition

Clinical description

An illness resulting from toxin produced by *Clostridium botulinum* that has infected a wound. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

Laboratory criteria for diagnosis

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

Case classification

Confirmed: a clinically compatible case that is laboratory confirmed in a patient who has no suspected exposure to contaminated food and who has a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms