

**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

**LISTERIOSIS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 64**

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.

List any specimen from which listeria was isolated
FOR CASES NOT ASSOCIATED WITH PREGNANCY

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State	State Public Health Lab Isolate Number
/ /		Blood				/ /		
/ /		CSF				/ /		
/ /		Vagina				/ /		
/ /		Tissue				/ /		
/ /		Stool				/ /		
/ /		Other, specify				/ /		

FOR CASES ASSOCIATED WITH PREGNANCY

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State	State Public Health Lab Isolate Number
/ /		Blood from mother				/ /		
/ /		Blood from neonate				/ /		
/ /		CSF from mother				/ /		
/ /		CSF from neonate				/ /		
/ /		Stool from mother				/ /		
/ /		Placenta				/ /		
/ /		Amniotic fluid				/ /		
/ /		Other, specify				/ /		
/ /		Other, specify				/ /		

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U If yes, symptom onset date (mm/dd/yyyy): ___/___/___ CHECK ALL THAT APPLY: Fever <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> Yes, subjective <input type="checkbox"/> No <input type="checkbox"/> Yes, measured <input type="checkbox"/> Unknown Highest measured temperature _____	Fever onset date (mm/dd/yyyy): ___/___/___ Shock <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Altered mental status <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Patient displayed (select all that apply) <input type="checkbox"/> Delirium <input type="checkbox"/> Coma Headache <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Meningitis <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Onset date (mm/dd/yyyy): ___/___/___	Encephalomyelitis/meningoencephalitis <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Onset date (mm/dd/yyyy): ___/___/___ Febrile gastroenteritis <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Chills <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Muscle aches <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Stiff neck <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Preterm labor <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U (CONTINUED NEXT PAGE)
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Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

NC EDSS PART 2 WIZARD (CONTINUED)
COMMUNICABLE DISEASE

Arthritis Y N U
 Extent: One joint Multiple joints
 Type: Septic

Abscess/infected skin lesion
 (pyoderma) Y N U

Nausea Y N U

Vomiting Y N U

Abdominal pain or cramps Y N U

Diarrhea Y N U
 Describe (select all that apply)
 Bloody Watery
 Non-bloody Other
 Maximum number of stools in a 24-hour period: _____

Bacteremia Y N U
 Date of positive blood culture
 (mm/dd/yyyy) ____/____/____

Septicemia/sepsis Y N U

Other symptoms, signs, clinical findings, or complications consistent with this illness 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 / close contact to a person reported with this disease

Other, specify _____

Unknown

OTHER EXPOSURE INFORMATION

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

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 70 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:

PREGNANCY

Is the patient currently pregnant? ... Y N U
 Estimated delivery date ____/____/____

If pregnant, who is providing prenatal care? Y N U
 Name: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____
 Telephone: (____) _____ - _____

Number of weeks gestation at onset of illness? ____

Has the patient been pregnant in the last 12 months? Y N U

Outcome of pregnancy (single gestation or Twin 1)	Weeks gestation	Date	Outcome of pregnancy (Twin 2)	Weeks gestation	Date
Still pregnant		/ /			/ /
Fetal death (miscarriage or stillbirth)		/ /			/ /
Induced abortion		/ /			/ /
Delivery (live birth)		/ /			/ /
Other, specify _____		/ /			/ /

Types of illness in mother	Types of illness in Twin 1	Types of illness in Twin 2
<input type="checkbox"/> Bacteremia/sepsis	<input type="checkbox"/> Bacteremia/sepsis	<input type="checkbox"/> Bacteremia/sepsis
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Febrile gastroenteritis	<input type="checkbox"/> Febrile gastroenteritis	<input type="checkbox"/> Febrile gastroenteritis
<input type="checkbox"/> Amnionitis	<input type="checkbox"/> Amnionitis	<input type="checkbox"/> Amnionitis
<input type="checkbox"/> Non-specific "flu-like" illness	<input type="checkbox"/> Non-specific "flu-like" illness	<input type="checkbox"/> Non-specific "flu-like" illness
<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Other, specify _____
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None

Was mother hospitalized for listeriosis?	Was Twin 1 hospitalized for listeriosis?	Was Twin 2 hospitalized for listeriosis?
<input type="checkbox"/> Yes Admit date ____/____/____ Discharge date ____/____/____	<input type="checkbox"/> Yes Admit date ____/____/____ Discharge date ____/____/____	<input type="checkbox"/> Yes Admit date ____/____/____ Discharge date ____/____/____
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
<input type="checkbox"/> Survived	<input type="checkbox"/> Survived	<input type="checkbox"/> Survived
<input type="checkbox"/> Died	<input type="checkbox"/> Died	<input type="checkbox"/> Died
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

INFANT BIRTH INFORMATION

Infant gestational age at birth:
 Full term Premature Unknown

Number of weeks gestation _____

Vital status:

Born alive and still alive

Born alive and then died

Stillborn

Unknown

If died, date of child death ____/____/____
 Give cause(s) of death from death certificate

Was an autopsy performed? Y N U
 Give final anatomical diagnosis

Was the case diagnosed while pregnant or within 2 weeks of delivery or miscarriage? Y N U

Indicate outcome of pregnancy:

Normal delivery Date of delivery ____/____/____

Stillbirth Date of stillbirth ____/____/____

Miscarriage Date of miscarriage ____/____/____

On-going Expected date of delivery ____/____/____

Was the case a newborn? Y N U

Mother's outcome	Neonate 1's (twin 1's) outcome	Neonate 2's (twin 2's) outcome
<input type="checkbox"/> Survived	<input type="checkbox"/> Survived	<input type="checkbox"/> Survived
<input type="checkbox"/> Died	<input type="checkbox"/> Died	<input type="checkbox"/> Died
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

MATERNAL INFORMATION

Did biologic mother have confirmed listeria infection during this pregnancy? Y N U

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

FOOD RISK AND EXPOSURE

During the 70 days prior to onset of symptoms, did the patient eat any raw or undercooked meat or poultry? Y N U

Specify meat/poultry: _____

Specify place of exposure: _____

During the 70 days prior to onset of symptoms, did the patient eat any raw or undercooked seafood or shellfish (i.e., raw oysters, sushi, etc.)? Y N U

Specify type of seafood/shellfish _____

Specify place of exposure _____

Where does the patient/patient's family typically buy groceries?

Store name: _____

Store city: _____

Shopping center name/address: _____

During the 70 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: _____

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): _____

Handle raw meat other than poultry? Y N U

Specify type of meat:

- Beef (hamburger/steak, etc)
- Pork (ham, bacon, pork chops, sausage, etc)
- Lamb/mutton
- Wild game, specify: _____
- Other, specify: _____
- Unknown

Handle raw poultry? Y N U

Specify type of poultry:

- Chicken
- Turkey
- Other, specify: _____
- Unknown

Drink unpasteurized milk? Y N U

Specify type of milk:

- Cow
- Goat
- Sheep
- Other, specify: _____
- Unknown

Eat any other unpasteurized dairy products? Y N U

Specify type of product:

- Queso fresco, Queso blanco or other Mexican soft cheese
- Butter
- Cheese from raw milk, specify: _____
- Food made from raw dairy product, specify: _____
- Other, specify: _____

Drink unpasteurized juices or ciders? Y N U

Specify juices or ciders:

- Apple
- Orange
- Other, specify: _____

Eat ground beef/hamburger? Y N U

Eat other beef/beef products? Y N U

- Roast
- Steak
- Other, specify: _____

Eat any poultry/poultry product? Y N U

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 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
- Mackerel
- Skip Jack or Amberjack
- Bonito
- Mahi-mahi (dorado/"blue dolphin")
- Sushi, unknown type of fish
- Other: specify _____
- Unknown
- Puffer fish
- Parrot fish
- Porcupine fish
- Ocean sunfish (Mola mola)
- Bluefish
- Salmon

Handle/eat other seafood (i.e. octopus, squid) or frogs? Y N U

Specify other seafood:

- Squid
- Octopus
- Frog
- Other, specify: _____

Eat raw fruit? Y N U

Specify raw fruit:

- Apples
- Bananas
- Oranges
- Grapes, specify: _____
- Pears
- Peaches
- Berries, specify _____
- Melon, specify _____
- Mangoes
- 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
- Parsley
- Oregano
- Cumin
- Other, specify: _____
- Thyme
- Cilantro
- Rosemary

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 deli-sliced (not pre-packaged) cheese? Y N U

Specify type of deli-sliced cheese:

- Cheddar
- Swiss
- American
- Other cheese, 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: _____

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

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): ____/____/____

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: _____

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: _____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? Y N U

Check all that apply:

Work Sexual behavior

Child care Blood and Body Fluid

School Other

Date control measures issued: ____/____/____

Date control measures ended: ____/____/____

Was patient compliant with control measures? Y N U

Did local health director or designee implement additional control measures? Y N

If yes, specify: _____

Were written isolation orders issued? Y N U

If yes, where was the patient isolated? _____

Date isolation started: ____/____/____

Date isolation ended: ____/____/____

Was the patient compliant with isolation? Y N U

BEHAVIORAL RISK & CONGREGATE LIVING

During the 70 days 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 70 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? Y N U

If yes, specify: _____

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

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): ____/____/____

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"/> Doctor's office/ Outpatient clinic
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> International
<input type="checkbox"/> Military	<input type="checkbox"/> Community
<input type="checkbox"/> Prison/Jail/Detention Center	<input type="checkbox"/> Other (specify) _____
	<input type="checkbox"/> Unknown

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

Notes: _____

Listeriosis (*Listeria monocytogenes*)

1999 CDC Case Definition

Clinical description

In adults, invasive disease caused by *Listeria monocytogenes* manifests most commonly as meningitis or bacteremia; infection during pregnancy may result in fetal loss through miscarriage or stillbirth, or neonatal meningitis or bacteremia. Other manifestations can also be observed.

Laboratory criteria for diagnosis

- A. Isolation of *L. monocytogenes* from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, joint, pleural, or pericardial fluid)
- B. In the setting of miscarriage or stillbirth, isolation of *L. monocytogenes* from placental or fetal tissue

Case classification

Confirmed: A clinically compatible case that is laboratory-confirmed

Comment:

The usefulness of other laboratory methods such as fluorescent antibody testing or polymerase chain reaction to diagnose invasive listeriosis has not been established.