

**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

SHIGELLOSIS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 39

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:
Fever Y N U
 Highest measured temperature _____
 Fever onset date (mm/dd/yyyy): ___/___/___
 How taken: _____
Chills or rigors 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
 Non-bloody
 Watery
 Other
 Maximum number of stools in a 24-hour period: _____
Bacteremia Y N U
 If yes, date of positive blood culture (mm/dd/yyyy): ___/___/___
Other symptoms, signs, clinical findings, or complications consistent with this illness? Y N U
 If yes, specify: _____
Is patient in child care? Y N U
 Name of care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (_____) _____

Patient wears diapers or shares a classroom with diapered children? Y N U
 Who wears diapers?
 Patient Classmate
 Give names of all child health care arrangements attended by the patient that involve diapering (patient wears diapers or other children in the same group wear diapers).

Is patient a child care worker or volunteer in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (_____) _____

Is patient a parent or primary caregiver of a child in child care? Y N U
 Name of child care provider: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (_____) _____

Is patient a student? Y N U
 Type of school:
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University

Other academic institution (i.e. trade school, professional school, etc)
 Name: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Contact name: _____
 Telephone: (_____) _____
 Specify grade: _____

Is patient a school WORKER / VOLUNTEER in NC school setting? Y N U
 Type of school
 NC Public School (preK-12)
 NC Private School (preK-12)
 Other School (preK-12)
 Community College/College/University
 Other academic institution (i.e. trade school, professional school, etc)
 Name: _____
 Address: _____
 City: _____ State: _____
 Zip code: _____ County: _____
 Telephone: (_____) _____

Notes:

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

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

TREATMENT

Did patient take an antibiotic as treatment for this illness? Y N U
Specify antibiotic name: _____
Date antibiotic began (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): ___/___/___

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? Y N
Check all that apply:
 Work Sexual behavior
 Child care Blood and body fluid
 School Other, specify _____
 Date control measures issued: ___/___/___
 Date control measures ended: ___/___/___
 Was patient compliant with control measures? Y N
Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) Y N
 If yes, specify: _____
Were written isolation orders issued? Y N
 If yes, where was the patient isolated? _____
 Date isolation started: ___/___/___
 Date isolation ended: ___/___/___
 Was the patient compliant with isolation? Y N
Were written quarantine orders issued? Y N
 If yes, where was the patient quarantined? _____
 Date quarantine started: ___/___/___
 Date quarantine ended: ___/___/___
 Was the patient compliant with quarantine? Y N

BEHAVIORAL RISK & CONGREGATE LIVING

During the 7 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 ___/___/___ to ___/___/___

During the 7 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? 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): ___/___/___

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 7 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: _____

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? Y N U
 If yes, specify: _____
During the 7 days prior to onset of symptoms did the patient have contact with sewage or human excreta? Y N U

FOOD RISK AND EXPOSURE

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

FOOD RISK AND EXPOSURE

During the 7 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: _____
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
Does the patient have a water softener or water filter installed inside the house to treat their water? Y N U
During the 7 days prior to onset of symptoms, did the patient drink any bottled water? Y N U
 Specify type/brand: _____
Where does the patient/patient's family typically buy groceries?
 Store name: _____
 Store city: _____
 Shopping center name/address: _____
During the 7 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): _____
During the 7 days prior to onset of symptoms, was the patient:
Employed as food worker? Y N U
 Where employed? _____
 Specify job duties: _____
 What dates did the patient work?
 From ___/___/___ to ___/___/___
Employed as food worker while symptomatic? Y N U
 Where did the patient work? _____
 What dates did the patient work?
 From ___/___/___ to ___/___/___
 What day did the patient return to food service work?
 Date: _____
 Where did patient return to work? _____

CONTINUED ON NEXT PAGE

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

FOOD RISK AND EXPOSURE (CONTINUED)

During the 7 days prior to onset of symptoms, was the patient: **Non-occupational food worker** (e.g. potlucks, receptions) during contagious period? Y N U

Where employed? _____
Specify dates worked during contagious period:
From ___/___/___ to ___/___/___

Health care worker or child care worker handling food or medication in the contagious period? Y N U

Where employed? _____
Specify dates worked during contagious period:
From ___/___/___ to ___/___/___

During the 7 days prior to onset of symptoms, did the patient:

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

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 Thyme
 Parsley Cilantro
 Oregano Rosemary
 Cumin
 Other, 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: _____

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:

WATER EXPOSURE

During the 7 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water, including aerosolized water in household, community or health care settings? Y N U

Activity(ies):
 Playing, wading, splashing
 Swimming
 Other, specify _____

Notes:

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 U

Notes:

Shigellosis (*Shigella spp.*)

2005 CDC Case Definition

Clinical description

An illness of variable severity characterized by diarrhea, fever, nausea, cramps, and tenesmus. Asymptomatic infections may occur.

Laboratory criteria for diagnosis

- Isolation of *Shigella* from a clinical specimen

Case classification

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case.

Confirmed: a case that meets the laboratory criteria for diagnosis. When available, O antigen serotype characterization should be reported.

Comment

For users of the legacy National Electronic Telecommunications System for Surveillance (NETSS), laboratory-confirmed isolates are also reported via the Public Health Laboratory Information System (PHLIS), which is managed by the Foodborne and Diarrheal Diseases Branch, Division of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC. The National Electronic Disease Surveillance System (NEDSS) or NEDSS compatible systems will eventually replace PHLIS; users of NEDSS or compatible systems which report to CDC should not report via PHLIS.

Both asymptomatic infections and infections at sites other than the gastrointestinal tract, if laboratory confirmed, are considered confirmed cases that should be reported.