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

TYPHOID FEVER, ACUTE

Confidential Communicable Disease Report—Part 2

NC DISEASE CODE: 44

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
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature____________
Fever onset date (mm/dd/yyyy):______________
Fatigue or malaise or weakness..............☐ Y ☐ N ☐ U
Loss of appetite (anorexia)..............☐ Y ☐ N ☐ U
Altered mental status..............☐ Y ☐ N ☐ U
Sweats (diaphoresis)..............☐ Y ☐ N ☐ U
Night sweats..............☐ Y ☐ N ☐ U
Headache..............☐ Y ☐ N ☐ U
Cough..............☐ Y ☐ N ☐ U
Onset date (mm/dd/yyyy):______________
Productive..............☐ Y ☐ N ☐ U
Enlarged spleen (splenomegaly)..............☐ Y ☐ N ☐ U
Rose spots..............☐ Y ☐ N ☐ U
Parotidis..............☐ Y ☐ N ☐ U
Constipation..............☐ Y ☐ N ☐ U
Partial hearing loss..............☐ 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:_____

During the 60 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?
____

During the 60 days prior to onset of symptoms, was the patient: Employed as food worker while symptomatic?..............☐ Y ☐ N ☐ U
Where did the patient work? ________________
What dates did the patient work?
____
What day did the patient return to food service work?
Date:________________________________
Where did patient return to work?_____________
A non-occupational food worker?
(e.g. potlucks, receptions) during contagious period..............☐ Y ☐ N ☐ U
Where employed?____________________________
Specify dates worked during contagious period:
____
A 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:
____
Comments:

PREDISPOSING CONDITIONS

Any immunosuppressive conditions..............☐ Y ☐ N ☐ U
Please specify: ________________________
Previously known typhoid carrier..............☐ Y ☐ N ☐ U
Other underlying illness..............☐ Y ☐ N ☐ U
Specify: ________________________________
Receiving treatment or taking any medications..............☐ Y ☐ N ☐ U
☐ Immunosuppressive therapy, including anti-rejection therapy
Specify ________________________
Was medication taken/therapy provided within the last 30 days before this illness?..............☐ Y ☐ N ☐ U
For what medical condition? ________________

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 the patient take an antibiotic for this illness?..............☐ Y ☐ N ☐ U
Specify antibiotic name: ____________________
Date antibiotic ended: ______________________

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): ____/____/____

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

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 60 days prior to onset of symptoms? .... ☐ Y ☐ N ☐ U

List travel dates and destinations _______________

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 60 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: __________________________

During the 60 days 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?

☐ 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

During the 60 days prior to onset, did the patient have sexual contact with a known carrier of this disease?.............................. ☐ Y ☐ N ☐ U

Did the partner(s) become ill with the same symptoms?..................................... ☐ Y ☐ N ☐ U

Since disease onset, has the patient had sexual contact with other(s)?.................... ☐ Y ☐ N ☐ U

Did the partner(s) become ill with the same symptoms?..................................... ☐ Y ☐ N ☐ U

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 60 days prior to onset of symptoms, did the patient work or volunteer in a health care or clinical setting?.............................. ☐ Y ☐ N ☐ U

Facility name _____________________________

City ___________________________ State _______

Country __________________________________

Occupation:

☐ Physician
☐ Physician's assistant or nurse practitioner
☐ Nurse
☐ Laboratory
☐ Other ____________________________
☐ Unknown

Specify work setting or volunteer duties __________

OTHER EXPOSURE INFORMATION

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

If yes, specify:

During the 60 days prior to onset of symptoms did the patient have contact with sewage or human excreta?.............................. ☐ Y ☐ N ☐ U

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

FOOD RISK AND EXPOSURE

During the 60 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 60 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 60 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 60 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): ____________

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: ____________

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 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 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: ____________

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: ____________

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 regarding setting of exposure:

VACCINE

Has patient / contact ever received vaccine related to this disease? ☐ Y ☐ N ☐ U

Vaccine type: ____________

Date last dose received (mm/dd/yyyy): ____________

Source of vaccine information:
- ☐ Patient's or Parent's verbal report
- ☐ Physician
- ☐ Medical record
- ☐ Certificate of immunization record
- ☐ Patient vaccine record
- ☐ School record
- ☐ Other, specify: ____________
- ☐ Unknown

Typhoid Fever *(Salmonella typhi)*

1997 CDC Case Definition

Clinical description

An illness caused by *Salmonella typhi* that is often characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and nonproductive cough. However, many mild and atypical infections occur. Carriage of *S. typhi* may be prolonged.

Laboratory criteria for diagnosis

- Isolation of *S. typhi* from blood, stool, or other clinical specimen

Case classification

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case in an outbreak

Confirmed: a clinically compatible case that is laboratory confirmed

Comment

Isolation of the organism is required for confirmation. Serologic evidence alone is not sufficient for diagnosis. Asymptomatic carriage should not be reported as typhoid fever. Isolates of *S. typhi* are reported to the Foodborne and Diarrheal Diseases Branch, Division of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC, through the Public Health Laboratory Information System.