County of Los Angeles Public Health

SALMONELLOSIS CASE REPORT

DO NOT USE FOR SALMONELLA TYPHI (TYPHOID FEVER)

Acute Communicable Disease Control
313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012
213-240-7941 (phone) 213-482-4856 (facsimile)
www.lapublichealth.org/acd

Group: _____ Serotype: _____ Presumptive ☐

Census tract: _____ VCMR ID: _____

Patient name-last	first	middle initial	Date of Birth	Age	Sex

Address- number, street	City	State	ZIP Code

Telephone number Home ( )	Work ( )	Cell ( )

Race (check one)
☐ African-American/Black ☐ Asian/Pacific Islander ☐ Native American ☐ White ☐ Other: _____

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

If Asian/Pacific Islander, please check one: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian ☐ Hawaiian ☐ Japanese ☐ Korean ☐ Laotian ☐ Samoan ☐ Vietnamese ☐ Other: _____

Occupation or school (give city/zip code)

Homeless? Yes ☐ No ☐

Sensitive Occupation/Situation(S.O.S)? Yes ☐ No ☐

PRESENT ILLNESS

Did patient have symptoms? ☐ Yes ☐ No ☐ Unknown

If Yes, Onset date ___/___/_____ Time _____

Duration of symptoms (in days) _____

Symptoms of illness (Check all that apply.)

Diarrhea	☐ Yes	☐ No	☐ Unknown
Bloody Diarrhea	☐ Yes	☐ No	☐ Unknown
Nausea	☐ Yes	☐ No	☐ Unknown
Vomiting	☐ Yes	☐ No	☐ Unknown
Fever (≥38° C,100° F)	☐ Yes	☐ No	☐ Unknown
Abdominal cramps	☐ Yes	☐ No	☐ Unknown

Other-Specify. _____

_____

Medical History/Complications ☐ None ☐ Cancer ☐ Diabetes ☐ Immunocompromised
☐ Pre-existing Gastrointestinal Disease ☐ Pregnant: Estimated due date ___/___/_____
☐ Renal Disease ☐ Other – Specify. _____

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown
If Yes, Admit date: ___/___/_____ Discharge date: ___/___/_____

Facility/Hospital Name

Attending or consulting physician | Telephone number ( )

Transferred to/from another hospital: ☐ Yes ☐ No ☐ Unknown
If Yes, Hospital name _____ Admit date ___/___/_____

Did patient die? ☐ Yes ☐ No ☐ Unknown If Yes, Date of death ___/___/_____

DIAGNOSTIC TESTS *(Attach laboratory results if available.)*

Culture confirmed? ☐ Yes ☐ No

If Yes, Source of specimen ☐ Stool ☐ Blood ☐ Urine ☐ None ☐ Other –Specify. _____

Date of collection ___/___/_____

Laboratory name _____ Phone number ( ) _____

SOURCES OF REPORT

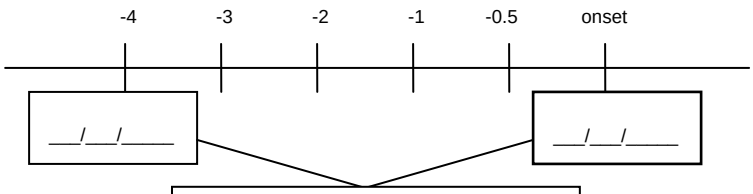
Who reported the case? ☐ Laboratory ☐ Physician ☐ Public Health Laboratory ☐ Infection Control Practitioner ☐ Other –Specify. _____

First reporter name _____ Phone number ( ) _____ First report date ___/___/_____

EPIDEMIOLOGIC RISK FACTORS

CALCULATE EXPOSURE PERIOD

Enter onset date in heavy box at right. Count back 4 days and insert date into the left box to figure out probably exposure period.



Ask about exposures between these dates

Note:
1) Usual communicable period up to 5 weeks, unless treated.
2) Communicable period= time of fecal excretion.
3) Antibiotic therapy may prolong carriage.

Patient name (last, first) _____ Date of Birth _____ VCMR ID: _____

EPIDEMIOLOGIC RISK FACTORS (Continued)

☐ No risk factors could be identified ☐ Patient could not be interviewed

During the exposure period, was the case:

Associated with a known outbreak? ☐ Yes ☐ No ☐ Unknown If Yes, Outbreak (OB) number? _____

A close contact of a confirmed or presumptive case? ☐ Yes ☐ No ☐ Unknown If Yes, Has the above case been reported? ☐ Yes ☐ Not Yet

Specify nature of contact: ☐ Household ☐ Sexual ☐ Daycare ☐ Other Name of linked case: _____

During the exposure period, did the case have: Medical procedures ☐ Yes ☐ No ☐ Unknown

Alternative medicine procedures (e.g. high colonic enema) ☐ Yes ☐ No ☐ Unknown

In the 4 days prior to onset, did case (>=15 yrs.) have sex with: ☐ Men ☐ Women ☐ Both ☐ None ☐ Refused to Answer

SUSPECT FOODS *(4 days before onset)*				**OTHER POTENTIAL SOURCES *(4 days before onset)***			
Yes	No	Unknown	(if yes, indicate date)	Yes	No	Unknown	(if yes, indicate date)
☐	☐	☐	Rare/raw meat or poultry	☐	☐	☐	Use folk/herbal remedies (e.g. rattlesnake)
☐	☐	☐	Raw/slightly cooked eggs, or in foods (sauces;	☐	☐	☐	Livestock, poultry, or wild birds
			homemade eggnog; ice cream; or mayonnaise)	☐	☐	☐	Pets-including cats, dogs, birds, exotic animals
☐	☐	☐	Goat (e.g. birria)	☐	☐	☐	Reptiles (lizards, snakes, turtles, other _____)
☐	☐	☐	Raw milk, unpasteurized cheese, other raw dairy -	☐	☐	☐	Animal/reptile culture taken? Date.____/____/___
			Detail exposure. _____	☐	☐	☐	Persons with diarrheal illness
☐	☐	☐	Raw/unpasteurized juice (brand) _____	☐	☐	☐	Diapered children or adults
☐	☐	☐	Food eaten outside of home (e.g. restaurant, fast	☐	☐	☐	Exposure to human excreta: Specify. _____
			food, food trucks, street vendors)	☐	☐	☐	Overnight visitors from abroad: Where? _____
☐	☐	☐	Food at gatherings (e.g. potlucks, catered, events)	☐	☐	☐	Travel outside the U.S. to _____
☐	☐	☐	Sprouts: Type _____	☐	☐	☐	Travel inside the U.S. to _____
☐	☐	☐	Raw vegetables/fruits: Specify. _____				Travel dates: ____/ ____/____ to ____/____/___
☐	☐	☐	Other suspect food. _____				

SENSITIVE OCCUPATION/SITUATION (SOS)

During communicable period (<=5 wks after onset), did case prepare food for any public or private gatherings? ☐ Yes ☐ No ☐ Unknown

If Yes, Provide details here. _____

Does the case or household contact attend daycare or pre-school? ☐ Yes ☐ No ☐ Unknown

If Yes, Is the case/contact in diapers? ☐ Yes ☐ No ☐ Unknown Are other children or staff ill? ☐ Yes ☐ No ☐ Unknown

Is the case or household contact a food handler, a HCW with direct patient contact, or childcare worker? ☐ Yes ☐ No ☐ Unknown

*If **case** attends/works at daycare/foodhandler/HCW:*	*If **contact** attends/works at daycare/foodhandler/HCW:*
Employer/Situation	Name of contact
Address	Employer/Situation Phone ( )
City Phone ( )	Address City
Notes:	Notes:

REMARKS - EXPOSURE DETAILS (Complete for any "Yes" answer – e.g. names of restaurants, market, foods eaten, dates, etc.)

Suspected Source

FOLLOW-UP CHECKLIST: Provide details as appropriate.

☐ Preventive/Education per B-73 ☐ Work or daycare restriction for case per B-73 ☐ FBI filed # _____

☐ Daycare inspection by PHN ☐ Follow-up of other household member(s) ☐ OB opened # _____

Public Health Nurse (PHN) Name (print)	PHN Signature			Telephone number ( )	Date ___/___/_____
PHNS Name (print)	PHNS Signature	Date ___/___/_____	Physician Name (print)	Physician Signature	Date ___/___/_____

CONTACT ROSTER FOR SALMONELLA / SHIGELLA / CAMPYLOBACTER (circle one)

Name of case: _____ **Onset date:** __ / __ / __ **Date of 1st positive culture:** __ / __ / __

HOUSEHOLD CONTACTS

/	Name Relationship	Age DOB	Occupation -**or**- School & Grade	SOS? ✔	Symptoms? ✔	Onset date	Confirmed? ✔	Presumptive?* ✔	Comments	Specimen Collection Dispensed	Collected	Results
1				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
2				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
3				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
4				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
5				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				
6				Yes ☐ No ☐	Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐				

NON-HOUSEHOLD CONTACTS WITH SIMILAR ILLNESS

/	Name	Age DOB	Address City	Phone number	Onset date	SOS? ✔	Confirmed case? ✔	Presumptive case? * ✔	Referred to: ✔	Comments (e.g. common meal, daycare, etc.)
1						Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	ACD ☐ District ☐	
2						Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	ACD ☐ District ☐	
3						Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	ACD ☐ District ☐	
4						Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	ACD ☐ District ☐	

* **Presumptive Case definition:** In a person epi-linked to a confirmed case, diarrhea (> 2 loose/24 hours) and fever **-or-** diarrhea and at least 2 other symptoms (e.g. cramps, vomiting, aches).

~Note: Follow-up for a presumptive case is the same as for a confirmed case. Also, a presumptive case is reportable: Epi-form must be filled out and the case entered into VCMR.