State of California—Health and Human Services Agency

Local ID Number: _____

California Department of Public Health
Center for Infectious Diseases
Division of Communicable Disease Control
Infectious Diseases Branch
Surveillance and Statistics Section
MS 7306, P.O. Box 997377
Sacramento, CA 95899-7377

S. TYPHI AND *S.* PARATYPHI INFECTION CASE REPORT

Check one: ☐ *Salmonella* Typhi ☐ *Salmonella* Paratyphi

Please complete this form for all confirmed and probable acute and convalescent cases of S. Typhi and S. Paratyphi A, B (tartrate negative), and C infection. Prompt, standardized interview of all cases of S. Typhi and S. Paratyphi is requested to improve the accuracy of recall of possible vehicles of infection.

*For all S. Typhi chronic carriers (cases without a clear symptom onset date and a history of S. Typhi >12 months ago, or that have had S. Typhi identified from their stool or urine > **12 months** from their initial symptom onset date), please use the **S. TYPHI CHRONIC CARRIER CASE REPORT**. **Note for S. Paratyphi B:** Persons with isolation of S. Paratyphi B **tartrate positive** from a clinical specimen should be reported as a salmonellosis case (not as a S. Paratyphi case).*

PATIENT INFORMATION

Last Name	*First Name*	*Middle Name*	*Suffix*

Social Security Number (9 digits)	*DOB (mm/dd/yyyy)*	*Age*	
Unknown			☐ Years ☐ Months ☐ Days

Address Number & Street – Residence	*Apartment / Unit Number*

City / Town	*State*	*Zip Code*

Census Tract	*County of Residence*	*Country of Residence*
	Los Angeles	USA

Country of Birth	*If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)*

Home Telephone	*Cellular Phone / Pager*	*Work / School Telephone*

E-mail Address	*Other Electronic Contact Information*

Work / School Location	*Work / School Contact*

Gender
☐ Female ☐ Male ☐ Trans female / transwoman ☐ Trans male/ transman ☐ Genderqueer or non-binary ☐ Identity not listed ☐ Unknown ☐ Declined to answer

Pregnant? ☐ Yes ☐ No ☐ Unknown	*If Yes, Est. Delivery Date (mm/dd/yyyy)*

Medical Record Number	*Patient's Parent/Guardian Name*

Occupation Setting (see list on page 12)	*Other Describe/Specify*

Occupation (see list on page 12)	*Other Describe/Specify*

Primary Language
☐ English
☐ Spanish
☐ Other: _____

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

Race(s)
(check all that apply, race descriptions on page 11)

The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.

☐ American Indian or Alaska Native

☐ Asian *(check all that apply, see list on page 11)*
- ☐ Asian Indian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Indonesian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Malaysian
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Taiwanese
- ☐ Thai
- ☐ Vietnamese
- ☐ Other: _____

☐ Black or African-American

☐ Native Hawaiian or Other Pacific Islander *(check all that apply, see list on page 11)*
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Fijian
- ☐ Tongan
- ☐ Guamanian
- ☐ Other: _____

☐ White

☐ Other: _____

☐ Unknown

First three letters of patient's last name: | | | |

ADDITIONAL PATIENT DEMOGRAPHICS

Sex Assigned at Birth
☐ Female ☐ Unknown
☐ Male ☐ Declined to answer

Sexual Orientation
☐ Heterosexual or straight ☐ Questioning, unsure, or patient doesn't know ☐ Declined to answer
☐ Gay, lesbian, or same-gender loving ☐ Orientation not listed ☐ Unknown
☐ Bisexual

CLINICAL INFORMATION

Physician Name - Last Name	*First Name*	*Telephone Number*

SIGNS AND SYMPTOMS

Symptomatic? ☐ Yes ☐ No ☐ Unknown	*If Yes, onset date of symptoms (mm/dd/yyyy)*	*Duration of Acute Symptoms (days)*	*Date First Sought Medical Care (mm/dd/yyyy)*

Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted	
Fever (>100.4°F or 38°C)	☐	☐	☐	*Onset Date of Fever (mm/dd/yyyy)*	*Duration of Fever (days)*
				Subjective or Measured Temperature ☐ Subjective ("felt hot") ☐ Measured ☐ Unknown	*If Measured, Highest Temperature (°F or °C)*
Cough	☐	☐	☐		
Abdominal cramps	☐	☐	☐		
Diarrhea (3 or more loose stools in a 24-hour period)	☐	☐	☐		
Bloody diarrhea	☐	☐	☐		
Constipation	☐	☐	☐		
Rose spots (Faint, salmon-colored macules on trunk and abdomen)	☐	☐	☐		

Other Signs / Symptoms

Complications	Yes	No	Unk	If Yes, Specify as Noted
Altered mental status	☐	☐	☐	
Seizures	☐	☐	☐	
Septic shock	☐	☐	☐	
Intestinal perforation	☐	☐	☐	*Was surgery required?* ☐ Yes ☐ No ☐ Unknown
Gallbladder surgery	☐	☐	☐	*Was gallbladder disease the presenting reason for hospitalization?* ☐ Yes ☐ No ☐ Unknown

Other Complications

PAST MEDICAL HISTORY

Did the patient receive typhoid vaccination (primary series or booster) within five years before onset of illness? ☐ Yes ☐ No ☐ Unknown	*If Yes, indicate type of vaccine received, if known.* ☐ Oral Ty21a or Vivotif (Berna) four pill series ☐ ViCPS or Typhim Vi shot (Pasteur Merieux) ☐ Typhoid conjugate vaccine shot (TCV, e.g., Typbar-TCV TYPHIBEV) ☐ Other (specify): _____ ☐ Unknown	*Year of Most Recent Vaccination (yyyy)*

Does the patient have a previous history of S. Typhi infection? ☐ Yes ☐ No ☐ Unknown	*Approximate Date (mm/yyyy)*	*Where was the diagnosis made? (City, State, Country)*

First three letters of patient's last name: | | | |

HOSPITALIZATION

Did the patient visit the emergency room for illness?
☐ Yes ☐ No ☐ Unknown

Was the patient hospitalized? ☐ Yes ☐ No ☐ Unknown	*If Yes, how many total hospital nights?*	*During any part of the hospitalization, did the patient stay in an intensive care unit (ICU) or a critical care unit (CCU)?* ☐ Yes ☐ No ☐ Unknown

If there were any ER visits or hospital stays related to this illness, specify details in the Hospitalization – Details section.

HOSPITALIZATION – DETAILS

Hospital Name 1	*Street Address*			*Admit Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*
Hospital Name 2	*Street Address*			*Admit Date (mm/dd/yyyy)*	
	City			*Discharge / Transfer Date (mm/dd/yyyy)*	
	State	*Zip Code*	*Telephone Number*	*Medical Record Number*	*Discharge Diagnosis*

TREATMENT / MANAGEMENT

Did the patient receive treatment? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify the treatment below.*

TREATMENT / MANAGEMENT – DETAILS

Antibiotic 1 Name
☐ Amoxicillin/Ampicillin ☐ Fluoroquinolone (e.g., ciprofloxacin, levofloxacin)
☐ Azithromycin ☐ Trimethoprim-sulfamethoxazole
☐ Carbapenem (e.g., Meropenem) ☐ Other (specify): _____
☐ Ceftriaxone

Patient finished antibiotics as prescribed? ☐ Yes ☐ No ☐ Unknown

Date Started (mm/dd/yyyy)

Date Ended (mm/dd/yyyy)

Antibiotic 2 Name
☐ Amoxicillin/Ampicillin ☐ Fluoroquinolone (e.g., ciprofloxacin, levofloxacin)
☐ Azithromycin ☐ Trimethoprim-sulfamethoxazole
☐ Carbapenem (e.g., Meropenem) ☐ Other (specify): _____
☐ Ceftriaxone

Patient finished antibiotics as prescribed? ☐ Yes ☐ No ☐ Unknown

Date Started (mm/dd/yyyy)

Date Ended (mm/dd/yyyy)

Antibiotic 3 Name
☐ Amoxicillin/Ampicillin ☐ Fluoroquinolone (e.g., ciprofloxacin, levofloxacin)
☐ Azithromycin ☐ Trimethoprim-sulfamethoxazole
☐ Carbapenem (e.g., Meropenem) ☐ Other (specify): _____
☐ Ceftriaxone

Patient finished antibiotics as prescribed? ☐ Yes ☐ No ☐ Unknown

Date Started (mm/dd/yyyy)

Date Ended (mm/dd/yyyy)

OUTCOME

Outcome? ☐ Survived ☐ Died ☐ Unknown	*If Survived, Survived as of* _____ *(mm/dd/yyyy)*	*Date of Death (mm/dd/yyyy)*

LABORATORY INFORMATION

LABORATORY TESTING RESULTS

Specimen Type
☐ Blood
☐ Gallbladder
☐ Stool
☐ Urine
☐ Other:_____
☐ Unknown

Type of Test (check all that apply)
☐ Culture ☐ Serologic: _____
☐ CIDT* ☐ Next generation/deep sequencing: _____
☐ Widal ☐ Other: _____
☐ Unknown
*Culture-independent diagnostic test (*e.g., PCR*)

Collection Date (mm/dd/yyyy)

Was this the first positive culture? ☐ Yes ☐ No ☐ Unknown

Culture Results
☐ Positive
☐ Negative
☐ Not done
☐ Unknown

Salmonella Serotype
☐ *S.* Typhi ☐ *S.* Paratyphi B tartrate negative* ☐ *S.* Paratyphi (serotype not specified) ☐ Unknown
☐ *S.* Paratyphi A ☐ *S.* Paratyphi C ☐ Other (specify): _____
*Note: A person with isolation of *S*. Paratyphi B tartrate positive from a clinical specimen should be categorized as a salmonellosis (not as a S. Paratyphi) case. *S*. Paratyphi B tartrate negative should be categorized as a *S*. Paratyphi case.

Laboratory Name	*Specimen ID*

LABORATORY TESTING RESULTS (continued)

ANTIMICROBIAL SUSCEPTIBILITY TESTING

Was antimicrobial susceptibility testing completed?
☐ Yes ☐ No ☐ Unknown

Attach additional results or upload to CalREDIE electronic filing cabinet.

Ampicillin	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
Azithromycin	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
Carbapenem (e.g., meropenem)	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
Ceftriaxone	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
Fluoroquinolones (e.g., ciprofloxacin, levofloxacin)	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
Trimethoprim-sulfamethoxazole	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done
Other antimicrobial (specify): _____	☐ Susceptible	☐ Intermediate	☐ Resistant	☐ Not done

PUBLIC HEALTH LABORATORY TESTING

Was isolate tested at a local public health lab? ☐ Yes ☐ No ☐ Unknown	*Local Public Health Laboratory Name*		*Local Laboratory Isolate ID Number*
Was isolate tested at a state public health lab? ☐ Yes ☐ No ☐ Unknown	*State Public Health Laboratory Name* ☐ MDL ☐ Other: _____		*State Laboratory Isolate ID Number*
Was whole genome sequencing (WGS) completed? ☐ Yes ☐ No ☐ Unknown	*Laboratory Name* ☐ MDL ☐ Other: _____	*WGS ID Number*	*Specify Results (e.g., allele code) or Attach*
Was isolate forwarded to CDC? ☐ Yes ☐ No ☐ Unknown	*Date Sent to CDC (mm/dd/yyyy)*	*Check if XDR** ☐ XDR	*CDC Laboratory Results / Comments / Notes*

*Extensively drug-resistant (XDR) Salmonella Typhi strains are resistant to at least five antibiotic classes: chloramphenicol, ampicillin, co-trimoxazole, fluoroquinolones, and third-generation cephalosporins.

EPIDEMIOLOGIC INFORMATION

INCUBATION PERIOD: 30 DAYS PRIOR TO ILLNESS ONSET

_____ **to** _____
(onset date minus 30 days) ***(onset date)***

TRAVEL HISTORY

Did the patient travel or live outside county of residence during the incubation period?
☐ Yes ☐ No ☐ Unknown

Did the patient travel or live outside the United States during the incubation period?
☐ Yes ☐ No ☐ Unknown

If Yes, date of most recent return or entry to the United States (mm/dd/yyyy)

Purpose of Travel (check all that apply)
☐ Tourism ☐ Visiting family and friends ☐ Other: _____
☐ Business ☐ Immigration to U.S.

If No, is patient a household or intimate contact of a person who traveled internationally?
☐ Yes ☐ No ☐ Unknown

If Yes to contact with an international traveler, provide contact's details below.

Contact's Name	*Contact's Phone Number*	*Contact's Relationship to Patient*

Date Travel Started (mm/dd/yyyy)	*Date Travel Ended (mm/dd/yyyy)*

International Travel Location(s) (country, city, resort, etc.)

***If the patient reported any international or domestic travel**, specify all locations and dates in the Travel History - Details section.*
***If the patient and close contacts did NOT have international travel,** contact CDPH Infectious Diseases Branch regarding possible domestically acquired case (510-620-3434) or email CDPH Typhi/Paratyphi subject matter expert.*

TRAVEL HISTORY – DETAILS

Travel Type	State	Country	Other location details (city, resort, etc.)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)
☐ Domestic ☐ International ☐ Unknown					
☐ Domestic ☐ International ☐ Unknown					
☐ Domestic ☐ International ☐ Unknown					

GROUP SETTINGS & OTHER EXPOSURES

Did the patient have any of the following exposures during the 30 days prior to illness onset?

Exposure	Yes	No	Unk	If Yes, Specify as Noted	
Attended child care or preschool	☐	☐	☐	*Location*	*Other Details*
Lived in a skilled nursing facility	☐	☐	☐	*Location*	*Other Details*
Lived in other congregate setting (e.g., LTCF, group home, prison, etc.)	☐	☐	☐	*Location*	*Other Details*
Experienced homelessness	☐	☐	☐	*Location and/or Shelter*	*Other Details*

HOUSEHOLD CONTACTS

How many people, besides the case, live in the household?	*Please provide details in HOUSEHOLD CONTACTS – DETAILS section below.*

HOUSEHOLD CONTACTS – DETAILS ***(If more than 4 household contacts, list additional contacts on page 13.)***

Name 1	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation*?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*
Name 2	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation*?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*
Name 3	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation*?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*
Name 4	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation*?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ■ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*

*Sensitive occupations/situations may include foodhandlers, patient care providers, and participation in group settings (such as daycare).

CONTACTS / OTHER ILL PERSONS

Is this case a contact to a known S. Typhi or S. Paratyphi carrier or case? ☐ Yes ☐ No ☐ Unknown	*If Yes, was the carrier or case previously known to the health department?* ☐ Yes ☐ No ☐ Unknown	*Contact's Name or CalREDIE #*	*Jurisdiction where Contact Lives*
		Has the jurisdiction where contact lives been contacted? ☐ Yes ☐ No ☐ Unknown	*Date Jurisdiction Contacted (mm/dd/yyyy)*
Any contact with similar illness? ☐ Yes ☐ No ☐ Unknown	*If Yes, list in the ILL CONTACTS – DETAILS section.*		

ILL CONTACTS – DETAILS ***(If more than 2 ill contacts, list additional contacts on page 13.)***

Name 1	*Age*	*Gender*	*Telephone Number*		*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address				*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City		*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown

(continued on page 6)

ILL CONTACTS – DETAILS (continued)

Name 2	*Age*	*Gender*	*Telephone Number*	*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address			*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City	*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown

CLEARANCE SPECIMENS: COMPLETE FOR ALL S. TYPHI AND FOR ALL S. PARATYPHI CASES IN A SENSITIVE OCCUPATION OR SITUATION (SOS) OR CHILD <5 YEARS OLD IN GROUP SETTING

Clearance Specimens:

- For all acute ***S.* Typhi** (<3 months from onset date)**, three** consecutive negative by culture stool and urine specimens taken at least 24 hours apart, beginning at least 1 week after discontinuation of antibiotics and not earlier than 1 month from onset, are **required.**
- For convalescent ***S.* Typhi** (≥3 months and <12 months from onset date)**, six** consecutive negative by culture stool and urine specimens taken at least 24 hours apart, beginning at least 1 week after discontinuation of antibiotics are **required.**
- For **chronic *S.* Typhi carriers** (≥ 12 months from onset date)**, six** consecutive negative stool and urine specimens taken at least 24 hours apart, beginning at least 1 week after discontinuation of antibiotics are **required**. Negative by culture specimens taken prior to the 12-month mark count towards clearance (negative cultures must be consecutive to count). However, a *S.* Typhi Chronic Carrier case report form should be started and all applicable clearance specimens should be documented there.
- For ***S.* Paratyphi** cases in SOS or children <5 years old in group setting, restriction/exclusion is required until two consecutive negative stool specimens taken at least 24 hours apart after discontinuation of antibiotics are negative (see salmonellosis guidelines).

See CACDC Enteric Disease Matrix for full details on **exclusion for contacts** and for **exclusion from work** criteria.

PATIENT CLEARANCE INFORMATION

Was clearance completed? ☐ Yes ☐ No ☐ Pending ☐ In Progress	*If Yes, Date of First Clearance Specimen (mm/dd/yyyy)*	*If Yes, Date of Final Clearance Specimen (mm/dd/yyyy)*
	If No, Specify Reason	
Is this patient in a sensitive occupation or situation? ☐ Yes ☐ No ☐ Unknown	*If Yes, which sensitive occupation or situation?* ☐ Foodhandler (e.g., works with, serves, or handles food) ☐ Healthcare (e.g., hospital, skilled nursing facility) ☐ Group setting (e.g., child care, institution, shelter) ☐ Other: _____	

Clearance Issues / Comments (including use of antibiotics and probiotics to facilitate clearance, etc.)

PATIENT EMPLOYMENT / SITUATION INFORMATION FOR CLEARANCE

Employer/Situation 1 (place of employment, daycare name, etc.)

Name of Employer Contact	*Telephone Number*	*Fax Number*	
Street Address	*City*	*State*	*Zip Code*

Employer/Situation 2 (place of employment, daycare name, etc.)

Name of Employer Contact	*Telephone Number*	*Fax Number*	
Street Address	*City*	*State*	*Zip Code*

CLEARANCE SPECIMEN TEST RESULTS – DETAILS

Clearance Specimen Type 1 ☐ Stool ☐ Urine ☐ Other: _____	*S. Typhi / S. Paratyphi Culture or CIDT* Result* ☐ Negative CIDT ☐ Positive CIDT ☐ Negative culture ☐ *S.* Typhi ☐ *S.* Paratyphi ☐ Unknown	
	Collection Date (mm/dd/yyyy)	*Laboratory Name*
Clearance Specimen Type 2 ☐ Stool ☐ Urine ☐ Other: _____	*S. Typhi / S. Paratyphi Culture or CIDT* Result* ☐ Negative CIDT ☐ Positive CIDT ☐ Negative culture ☐ *S.* Typhi ☐ *S.* Paratyphi ☐ Unknown	
	Collection Date (mm/dd/yyyy)	*Laboratory Name*

(continued on page 7)

CLEARANCE SPECIMEN TEST RESULTS – DETAILS (continued)

Clearance Specimen Type 3 ☐ Stool ☐ Urine ☐ Other: _____	*S. Typhi / S. Paratyphi Culture or CIDT* Result* ☐ Negative CIDT ☐ Positive CIDT ☐ Negative culture ☐ *S.* Typhi ☐ *S.* Paratyphi ☐ Unknown	
	Collection Date (mm/dd/yyyy)	*Laboratory Name*
Clearance Specimen Type 4 ☐ Stool ☐ Urine ☐ Other: _____	*S. Typhi / S. Paratyphi Culture or CIDT* Result* ☐ Negative CIDT ☐ Positive CIDT ☐ Negative culture ☐ *S.* Typhi ☐ *S.* Paratyphi ☐ Unknown	
	Collection Date (mm/dd/yyyy)	*Laboratory Name*
Clearance Specimen Type 5 ☐ Stool ☐ Urine ☐ Other: _____	*S. Typhi / S. Paratyphi Culture or CIDT* Result* ☐ Negative CIDT ☐ Positive CIDT ☐ Negative culture ☐ *S.* Typhi ☐ *S.* Paratyphi ☐ Unknown	
	Collection Date (mm/dd/yyyy)	*Laboratory Name*
Clearance Specimen Type 6 ☐ Stool ☐ Urine ☐ Other: _____	*S. Typhi / S. Paratyphi Culture or CIDT* Result* ☐ Negative CIDT ☐ Positive CIDT ☐ Negative culture ☐ *S.* Typhi ☐ *S.* Paratyphi ☐ Unknown	
	Collection Date (mm/dd/yyyy)	*Laboratory Name*

*Culture-independent diagnostic test

TREATMENT FOR CLEARANCE

Did the patient receive treatment specifically for clearance (and not just treatment of acute illness)? ☐ Yes ☐ No ☐ Unknown	*If Yes, specify details in the TREATMENT FOR CLEARANCE – DETAILS section.*

TREATMENT FOR CLEARANCE – DETAILS

Treatment 1 ☐ Antibiotic ☐ Gallbladder surgery ☐ Typhoid vaccine ☐ Other: _____	*If Antibiotic, Antibiotic Name* ☐ Amoxicillin/Ampicillin ☐ Carbapenem (e.g., Meropenem) ☐ Azithromycin ☐ Fluoroquinolone (e.g., ciprofloxacin, levofloxacin) ☐ Ceftriaxone ☐ Trimethoprim-sulfamethoxazole ☐ Other (specify): _____	*Date Started (mm/dd/yyyy)* *Date Ended (mm/dd/yyyy)* *Patient finished antibiotics as prescribed?* ☐ Yes ☐ No ☐ Unknown
	If Gallbladder Surgery, Date of Surgery (mm/dd/yyyy)	
	If Typhoid vaccine, specify vaccine ☐ Oral Ty21a or Vivotif (Berna) four pill series ☐ Other: _____ ☐ ViCPS or Typhim Vi shot (Pasteur Merieux) ☐ Unknown ☐ TCV Typhoid conjugate vaccine	*Date Completed (mm/dd/yyyy)*
Treatment 2 ☐ Antibiotic ☐ Gallbladder surgery ☐ Typhoid vaccine ☐ Other: _____	*If Antibiotic, Antibiotic Name* ☐ Amoxicillin/Ampicillin ☐ Carbapenem (e.g., Meropenem) ☐ Azithromycin ☐ Fluoroquinolone (e.g., ciprofloxacin, levofloxacin) ☐ Ceftriaxone ☐ Trimethoprim-sulfamethoxazole ☐ Other (specify): _____	*Date Started (mm/dd/yyyy)* *Date Ended (mm/dd/yyyy)* *Patient finished antibiotics as prescribed?* ☐ Yes ☐ No ☐ Unknown
	If Gallbladder Surgery, Date of Surgery (mm/dd/yyyy)	
	If Typhoid vaccine, specify vaccine ☐ Oral Ty21a or Vivotif (Berna) four pill series ☐ Other: _____ ☐ ViCPS or Typhim Vi shot (Pasteur Merieux) ☐ Unknown ☐ TCV Typhoid conjugate vaccine	*Date Completed (mm/dd/yyyy)*

NON-TREATMENT RELATED CLEARANCE ISSUES (e.g., impact of clearance on patient, difficulty in obtaining specimens, etc.)

NOTES / REMARKS

REPORTING AGENCY

Investigator Name	*Local Health Jurisdiction*	*Telephone Number*	*Date Form Completed (mm/dd/yyyy)*
	Los Angeles		

First Reported By

☐ Clinician ☐ Laboratory ☐ Other (specify): _____

OUTBREAK

Part of known outbreak?	*If Yes, extent of outbreak:*
☐ Yes ☐ No ☐ Unknown	☐ One CA jurisdiction ☐ Multiple CA jurisdictions ☐ Multistate ☐ International ☐ Unknown ☐ Other (specify): _____

Mode of Transmission	*Vehicle of Outbreak*	*Pattern 1 ID number*	*Pattern 2 ID number*
☐ Point source ☐ Person-to-person ☐ Unknown ☐ Other:_____			

STATE USE ONLY

State Case Classification

☐ Confirmed ☐ Probable ☐ Not a case ☐ Need additional information

CASE DEFINITION

***SALMONELLA* TYPHI INFECTION (2019)**

CLINICAL DESCRIPTION

Infections caused by *Salmonella* enterica serotype Typhi (*S.* Typhi) that are often characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and non-productive cough. However, mild and atypical infections may occur. Carriage of *S.* Typhi may be prolonged.

CLINICAL CRITERIA FOR DIAGNOSIS

One or more of the following: fever, diarrhea, abdominal cramps, constipation, anorexia, or relative bradycardia

LABORATORY CRITERIA FOR DIAGNOSIS

Confirmatory laboratory evidence

Isolation of *S.* Typhi from a clinical specimen.

Presumptive laboratory evidence

Detection of *S.* Typhi in a clinical specimen using a culture-independent diagnostic test (CIDT).

Note: Serologic testing (i.e., detection of antibodies to *S.* Typhi) should not be utilized for case classification.

EPIDEMIOLOGIC LINKAGE

- Epidemiological linkage to a confirmed *S.* Typhi Infection case, OR
- Epidemiological linkage to a probable *S.* Typhi Infection case with laboratory evidence, OR
- Member of a risk group as defined by public health authorities during an outbreak.

CASE CLASSIFICATION

Confirmed

A person with confirmatory laboratory evidence.

Probable:

- A clinically compatible illness in a person with presumptive laboratory evidence.
- A clinically compatible illness in a person with an epidemiological linkage.

COMMENT

Several serological tests have been developed to detect antibodies to *S*. Typhi. However, no current serological test is sufficiently sensitive or specific to replace culture-based tests for the identification of *S*. Typhi infections. Whether public health follow-up for positive serologic testing is conducted and how is at the discretion of the jurisdiction.

It is estimated that approximately 2-5% of persons infected with *S*. Typhi become chronic intestinal carriers who continue to shed *S*. Typhi for more than one year. These people are typically referred to as chronic carriers.

Differentiating whether a person is a chronic carrier or is experiencing a new infection often relies on a variety of factors, including advanced laboratory testing (e.g., pulsed-field gel electrophoresis [PFGE], whole genome sequencing [WGS]) to compare the isolate from the previous infection to the new isolate. While these methodologies can provide detailed information about the genetic make-up of the organisms, there is still significant variability in how two organisms can be defined as different. Given the potential for inconsistent application of the label "different" across jurisdictions, this case definition does not exclude persons with a previously reported S. Typhi Infection case from being counted as a new case if the subsequent positive laboratory result is more than 365 days from the most recent positive laboratory result associated with the existing case.

TYPHOID CARRIER CASE DEFINITION, RESTRICTIONS, AND SUPERVISION ADAPTED FROM TITLE 17, CCR, SECTION 2628

DEFINITION OF CARRIERS

1. **Convalescent Carriers**

   Any person who harbors typhoid bacilli for three or more months after onset is defined as a convalescent carrier.

2. **Chronic Carriers**

   If the person continues to excrete typhoid bacilli for more than 12 months after onset of typhoid fever, he/she is defined as a chronic carrier. Any person who gives no history of having had typhoid fever or who had the disease more than one year previously, and whose feces or urine are found to contain typhoid bacilli on two separate examinations at least 48 hours apart, confirmed by State's Microbial Diseases Laboratory, is also defined as a chronic carrier. All carriers shall be reported to the local health officer. Such reports shall be kept confidential and shall not be divulged to persons other than the carrier and his/her immediate family, except as may be required for the protection of the public health.

3. **Other Carriers**

   A person should be held under surveillance if typhoid bacilli are isolated from surgically removed tissues, organs, e.g., gall bladder, kidney, etc., or from draining lesions such as osteomyelitis. If the person continues to excrete typhoid bacilli for more than 12 months, he/she is defined as a chronic carrier and may be released after satisfying the criteria for other chronic carriers.

CASE DEFINITION (continued)

***SALMONELLA* PARATYPHI INFECTION (2019)**

BACKGROUND

S. Paratyphi A, B (tartrate negative), and C are bacteria that often cause a potentially severe and occasionally life-threatening bacteremic illness. Of note, *S*. Paratyphi B (tartrate positive), previously known as *S*. Java, typically causes an uncomplicated gastroenteritis, with lower rates of hospitalization and recent international travel compared with *S*. Paratyphi A, B (tartrate negative), and C. For these reasons, Paratyphi B (tartrate positive) is categorized as salmonellosis instead of an *S*. Paratyphi Infection.

CLINICAL DESCRIPTION

Infections caused by *Salmonella* enterica serotypes Paratyphi A, B (tartrate negative), and C (*S*. Paratyphi) that are often characterized by insidious onset of sustained fever, headache, malaise, anorexia, relative bradycardia, constipation or diarrhea, and non-productive cough. However, mild and atypical infections may occur. Carriage of *S*. Paratyphi A, B (tartrate negative), and C may be prolonged.

CLINICAL CRITERIA FOR DIAGNOSIS

One or more of the following: fever, diarrhea, abdominal cramps, constipation, anorexia, or relative bradycardia

LABORATORY CRITERIA FOR DIAGNOSIS

Confirmatory laboratory evidence

Isolation of *S*. Paratyphi A, B (tartrate negative), or C from a clinical specimen.

Presumptive laboratory evidence

Detection of *S*. Paratyphi A, B (tartrate negative), or C in a clinical specimen using a culture-independent diagnostic test (CIDT).

Note: Serologic testing (i.e., detection of antibodies to *S*. Paratyphi A, B, or C) should not be utilized for case classification.

EPIDEMIOLOGIC LINKAGE

- Epidemiological linkage to a confirmed *S*. Paratyphi Infection case, OR
- Epidemiological linkage to a probable *S*. Paratyphi Infection case with laboratory evidence, OR
- Member of a risk group as defined by public health authorities during an outbreak.

CASE CLASSIFICATION

Confirmed

A person with confirmatory laboratory evidence.

Probable

- A clinically compatible illness in a person with presumptive laboratory evidence.
- A clinically compatible illness in a person with an epidemiological linkage.

COMMENT

Persons with isolation of S. Paratyphi B (tartrate positive) from a clinical specimen should be categorized as a salmonellosis case.

Several serological tests have been developed to detect antibodies to *S*. Paratyphi A, B, and C. However, no current serological test is sufficiently sensitive or specific to replace culture-based tests for the identification of *S*. Paratyphi infections. Whether public health follow-up for positive serologic testing is conducted and how is at the discretion of the jurisdiction. The percentage of persons with *S*. Paratyphi A, B (tartrate negative), or C infections that become chronic carriers is not known.

First three letters of patient's last name: | | | |

RACE DESCRIPTIONS

Race	Description
American Indian or Alaska Native	Patient has origins in **any** of the original peoples of North and South America (including Central America).
Asian	Patient has origins in **any** of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in **any** of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in **any** of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in **any** of the original peoples of Europe, the Middle East, or North Africa.

ASIAN GROUPS

- Bangladeshi
- Bhutanese
- Burmese
- Cambodian
- Chinese
- Filipino
- Hmong
- Indian
- Indonesian
- Iwo Jiman
- Japanese
- Korean
- Laotian
- Madagascar
- Malaysian
- Maldivian
- Nepalese
- Okinawan
- Pakistani
- Singaporean
- Sri Lankan
- Taiwanese
- Thai
- Vietnamese

NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER GROUPS

- Carolinian
- Chamorro
- Chuukese
- Fijian
- Guamanian
- Kiribati
- Kosraean
- Mariana Islander
- Marshallese
- Melanesian
- Micronesian
- Native Hawaiian
- New Hebrides
- Palauan
- Papua New Guinean
- Pohnpeian
- Polynesian
- Saipanese
- Samoan
- Solomon Islander
- Tahitian
- Tokelauan
- Tongan
- Yapese

First three letters of patient's last name: | | | |

OCCUPATION SETTING

- Childcare/Preschool
- Correctional Facility
- Drug Treatment Center
- Food Service
- Health Care - Acute Care Facility
- Health Care - Long Term Care Facility
- Health Care - Other
- Homeless Shelter
- Laboratory
- Military Facility
- Other Residential Facility
- Place of Worship
- School
- Other

OCCUPATION

- Agriculture - farmworker or laborer (crop, nursery, or greenhouse)
- Agriculture - field worker
- Agriculture - migratory/seasonal worker
- Agriculture - other/unknown
- Animal - animal control worker
- Animal - farm worker or laborer (farm or ranch animals)
- Animal - veterinarian or other animal health practitioner
- Animal - other/unknown
- Clerical, office, or sales worker
- Correctional facility - employee
- Correctional facility - inmate
- Craftsman, foreman, or operative
- Daycare or child care attendee
- Daycare or child care worker
- Dentist or other dental health worker
- Drug dealer
- Fire fighting or prevention worker
- Flight attendant
- Food service - cook or food preparation worker
- Food service - host or hostess
- Food service - waiter or waitress
- Food service - other/unknown
- Homemaker
- Laboratory technologist or technician
- Laborer - private household or unskilled worker
- Manager, official, or proprietor
- Manicurist or pedicurist
- Medical - emergency medical technician or paramedic
- Medical - health care worker
- Medical - medical assistant
- Medical - pharmacist
- Medical - physician assistant or nurse practitioner
- Medical - physician or surgeon
- Medical - registered nurse
- Medical - other/unknown
- Military - officer
- Military - recruit or trainee
- Protective service - police officer
- Protective service - other
- Professional, technical, or related profession
- Retired
- Sex worker
- Student - preschool or kindergarten
- Student - elementary or middle school
- Student - high (secondary) school
- Student - college or university
- Student - other/unknown
- Teacher/employee - preschool or kindergarten
- Teacher/employee - elementary or middle school
- Teacher/employee - high (secondary) school
- Teacher/instructor/employee - college or university
- Teacher/instructor/employee - other/unknown
- Unemployed - seeking employment
- Unemployed - not seeking employment
- Unemployed - other/unknown
- Other
- Refused
- Unknown

First three letters of patient's last name: | | | |

HOUSEHOLD CONTACTS – DETAILS (continued from page 5)					
Name 5	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*
Name 6	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*
Name 7	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*
Name 8	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*
Name 9	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*
Name 10	*Relationship*	*Age*	*Gender*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
	Telephone Number	*Similar illness?* ☐ Yes ☐ No ☐ Unknown		*Onset Date (mm/dd/yyyy)*	*Comment*

ILL CONTACTS – DETAILS (continued from page 5)						
Name 3	*Age*	*Gender*	*Telephone Number*		*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address				*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City		*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
Name 4	*Age*	*Gender*	*Telephone Number*		*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address				*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City		*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown
Name 5	*Age*	*Gender*	*Telephone Number*		*Type of Contact / Relationship*	*Date of Contact (mm/dd/yyyy)*
	Street Address				*Exposure Event*	*Illness Onset Date (mm/dd/yyyy)*
	City		*State*	*Zip Code*	*Occupation*	*Sensitive occupation / situation?* ☐ Yes ☐ No ☐ Unknown