

Campylobacteriosis

acd-camp6/01

SEROTYPE _____ (Presumptive)

Census Tract _____ District _____

Name _____
 Last First MI
 Address _____
 Street Apt. #
 City County Zip
 Phone(s) (____) _____ (____) _____
 Home Work

Sources of Report

Lab Public Health Lab
 Physician Infection Control Practitioner
 Other _____
 (e.g. school, camp, etc...)

Name _____
 Phone (____) _____ Date ____/____/____
 First Report
 M.D./Provider _____
 Phone (____) _____

OCCUPATION _____ SEX Male Female AGE _____
 Date of Birth ____/____/____
 RACE Black Asian/Pacific Islander Unknown
 White American Indian _____
 HISPANIC Yes No Unknown

Clinical Data

Symptomatic: Yes No Unk
 if yes, ONSET on ____/____/____
 Duration of Symptoms ____ Days
 Check all that apply:

	Yes	No	Unk
diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bloody diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fever (____°F)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
abd cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
name of hospital	_____		
date of admission	____/____/____		
date of discharge	____/____/____		
Transferred to/from another hospital:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.		
transfer hospital name:	_____		
date of admission	____/____/____		
Outcome:	<input type="checkbox"/> Survive <input type="checkbox"/> Die <input type="checkbox"/> Unk		
date of death	____/____/____		

Medical History/Complications

Diabetes Renal Disease
 Immunocompromise Cancer
 Pre-exist. GI Disease Arthritis
 Pregnant: EDD ____/____/____
 Guillain-Barre' Meningitis
 Other _____ None

Laboratory Data

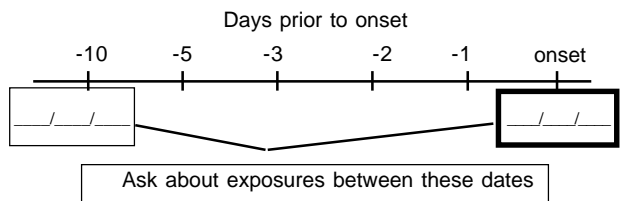
Culture confirmed: Yes No
 Specimen: Stool Blood
 None Urine _____
 Date specimen collected ____/____/____

Epidemiology Linkage

During the exposure period, was case:
 1. Associated with a known outbreak? Yes No Unknown
 If yes, Outbreak (OB) # _____
 2. A close contact of a confirmed or presumptive case? Yes No Unknown
 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 case have:
 3. Medical Procedures Yes No
 4. Alternative Medicine Procedures--e.g. high colonic enema Yes No
 If yes to above questions, specify relevant names, dates, places:

In the 10 days prior to onset, did case (>=15 yrs.) have sex with:
 Men Women Both None Refused to Answer

Enter onset date in heavy box at right. Count back 10 days and insert date into the left box to figure out probable exposure period.



Note: Usual communicable period up to 7 weeks, unless treated.
 Note: Communicable period = Time of fecal excretion.
 Note: Antibiotic therapy may prolong carriage.

no risk factors could be identified

patient could not be interviewed

SUSPECT FOODS (*within 10 days of onset*)

Yes No (*If yes, indicate dates*)

- rare/raw poultry or meat
- raw milk/unpasteurized milk products
(specify) _____
- food at restaurants
- food at gatherings (potlucks, events)
- untreated drinking water
- raw vegetables/fruits (specify) _____
- other suspect food _____

OTHER POTENTIAL SOURCES (*within 10 days of onset*)

Yes No

- recreational water exposure
- persons with diarrheal illness
- diapered children or adults
- exposure to human excreta: specify _____
- institutional/group setting
- travel outside the U.S. to _____
- travel inside the U.S. to _____

Dates of travel ________ - ________

Exposure Details (*complete for any "yes" answer - e.g. names of restaurants, markets, foods eaten, dates, etc.*)

Suspected Source

Sensitive Occupation/Situation (SOS)

During communicable period (<=7 wks after onset), did case prepare food for any public or private gatherings? Yes No
If yes, provide details here.

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

If yes: Is the case/contact in diapers? Yes No

Are other children or staff ill? Yes No

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

If case attends/works at daycare/foodhandler/HCW:

Employer/Situation _____

Address _____

City _____ Phone () _____

Notes:

If contact attends/works at daycare/foodhandler/HCW:

Name of contact _____

Employer/Situation _____ Phone () _____

Address _____ City _____

Notes:

SUMMARY OF FOLLOW-UP AND COMMENTS. Provide details as appropriate.

- Prevention/Education per B-73
- Daycare inspection by PHN
- Work or daycare restriction for case per B-73
- Follow-up of other household member(s)
- FBI filed # _____
- OB opened # _____

ADDITIONAL COMMENTS:

Remember to copy case's name onto the top of this page and complete/review contact roster, page 3, before signing below.

PHN Print name _____ PHN Signature _____ Date __/__/__ Phone () _____

PHNS Print name _____ M.D. Print Name _____

PHNS Signature _____ Date __/__/__ M.D. Signature _____ Date __/__/__

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

contact:acd6/01

Name of case: _____

Onset date: ___/___/___

Date of 1st positive culture: ___/___/___

HOUSEHOLD CONTACTS

/	Name Relationship	Age DOB	Occupation -or- School & Grade	SOS? ✓		Symptoms? ✓		Onset date	Confirm- ed? ✓		Presump- tive? * ✓		Comments	Specimen Collection		
				Yes	No	Yes	No		Yes	No	Yes	No		Dispensed	Collected	Results
1	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
2	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
3	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
4	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
5	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
6	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				

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.)	
						Yes	No	Yes	No	Yes	No			ACD
1	_____	_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	ACD <input type="checkbox"/>	District <input type="checkbox"/>	
2	_____	_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	ACD <input type="checkbox"/>	District <input type="checkbox"/>	
3	_____	_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	ACD <input type="checkbox"/>	District <input type="checkbox"/>	
4	_____	_____	_____	_____	_____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	ACD <input type="checkbox"/>	District <input type="checkbox"/>	

* **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.