



SUSPECT BOTULISM INTAKE FORM



AOD Name: _____ Today's Date: _____ Time: _____
 Report Source: _____ Agency: _____ Phone: _____
 Medical Contact: _____ Phone: _____
 Hospital Name: _____ Phone: _____
 Hospitalized? Yes No Date of hospitalization: _____

DEMOGRAPHICS Last Name: _____ First Name: _____
 DOB: _____ Age: _____ Sex: _____ Home Phone: _____
 Address: _____ City: _____ ZIP code: _____
 Race: Black White Native American Asian Other Ethnicity: Hispanic Non-Hispanic
 Friend/Family Contact: _____ Phone: _____

OUT OF JURISDICTION REPORTS

- Pasadena Resident - Refer to Pasadena Health Department for consultation & reporting (626) 744-6005 General/ 6089 PH Nursing/ 6043 Emergency After-hours
- Long Beach Resident - Refer to Long Beach Health Department for consultation & reporting (562) 570-4000 General/ 4302 Epidemiology
- Infant Botulism Case - Refer to State Infant Botulism Treatment and Prevention Program (510) 231-7600

CLINICAL STATUS Onset Date: _____

<u>Cranial Nerve</u>	Date	Time	<u>Systemic</u>	Date	Time
<input type="checkbox"/> Eye muscle involvement	_____	_____	<input type="checkbox"/> Pulse normal	_____	_____
<input type="checkbox"/> Blurred/double vision	_____	_____	<input type="checkbox"/> Respiration normal	_____	_____
<input type="checkbox"/> Ptosis	_____	_____	<input type="checkbox"/> Blood pressure normal	_____	_____
<input type="checkbox"/> Facial paralysis	_____	_____	<input type="checkbox"/> No fever	_____	_____
<input type="checkbox"/> Dry/sore throat	_____	_____	<input type="checkbox"/> Ventilatory support req'd	_____	_____
<input type="checkbox"/> Dysphagia (swallowing)	_____	_____	<input type="checkbox"/> Headache	_____	_____
<input type="checkbox"/> Dysphonia (speech)	_____	_____	<input type="checkbox"/> Dizzy	_____	_____
<input type="checkbox"/> Weak neck muscles	_____	_____	<input type="checkbox"/> Weakness/lassitude	_____	_____
<u>Neurological</u>			<u>Gastrointestinal</u>		
<input type="checkbox"/> No paresthesia	_____	_____	<input type="checkbox"/> Diarrhea	_____	_____
<input type="checkbox"/> Descending paralysis	_____	_____	<input type="checkbox"/> Constipation	_____	_____
<input type="checkbox"/> Clear Sensorium	_____	_____	<input type="checkbox"/> Abdominal cramps	_____	_____
<input type="checkbox"/> Diminished/absent deep tendon reflex	_____	_____	<input type="checkbox"/> Nausea	_____	_____
<input type="checkbox"/> No pain/discomfort	_____	_____	<input type="checkbox"/> Vomiting	_____	_____
<input type="checkbox"/> Urinary retention	_____	_____	<input type="checkbox"/> Other:	_____	_____

Clinical Tests

	Date	Result		Date	Result
<input type="checkbox"/> CSF	_____	_____	<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> Tensilon test	_____	_____	<input type="checkbox"/> CT Scan	_____	_____
<input type="checkbox"/> EMG-BSAP	_____	_____	<input type="checkbox"/> Other	_____	_____

Medications

Antibiotics

Name: _____	Date Started: _____
Name: _____	Date Started: _____
Name: _____	Date Started: _____

Other Medications

Name: _____	Date Started: _____
Name: _____	Date Started: _____
Name: _____	Date Started: _____

EPIDEMIOLOGY

Does the patient have a history of ingesting any unusual/high risk food items? Yes No

Suspect Food Item(s): _____

Home-canned Commercial Restaurant-associated Other food item Explain: _____

Date Eaten: _____ Time: _____

Others eating same food? Yes No No. Exposed _____ No. Ill _____

Does the patient have any visible wounds? Yes No

Site of wound/reason: _____

Date of injury: _____ Wound appears infected? Yes No

Anaerobic culture performed? Yes No Date: _____ Result: _____

Does the patient have a history of illicit drug use? Yes No

If Yes: Type of drug: _____ Mode of use (i.e. injection, skin popper, etc): _____

INITIAL IMPRESSIONS / ACTIONS TAKEN

Case Status

Case does not meet follow-up criteria, No further Public Health action necessary at this time

Case meets criteria for botulism:

suspect foodborne suspect wound unspecified at this time

Actions Taken

Approve specimen testing from PHL (call laboratory)

PHL Contact Name: _____ Date: _____ Time: _____

Pre-tx serum Gastric aspirate Stool Food item Wound aspirate/biopsy

Approve antitoxin release (call CDC quarantine station)

Quarantine Station Contact Name: _____ Date: _____ Time: _____

Treated with antitoxin? Yes No Date started: _____ No. of vials _____

Circle one: AB ABE E

Request assistance from EH with home inspection (for suspect foodborne botulism)

EH Contact Name: _____ Date: _____ Time: _____

