



Send completed forms to
DPHHS CDEpi Program
Fax: 800-616-7460

LHJ Use ID _____
 Reported to DPHHS Date ___/___/___
 LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Epi Link: _____

Salmonellosis

(Do not use for Typhoid Fever)

County _____

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___
 Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other
 Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____
 OK to talk to case? Yes No DK Date of interview ___/___/___

PATIENT INFORMATION

Name (last, first) _____ Birth date ___/___/___ Age _____
 Address _____ Homeless
 Gender F M Other Unk
 City/State/Zip _____ Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Phone(s)/Email _____
 Alt. contact Parent/guardian Spouse Other Name: _____
 Zip code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk

CLINICAL INFORMATION

---Case defining variables are in **bold**. Answers are: Yes, No, Unknown to case, Not asked /Not answered---

Onset date: ___/___/___ Derived Diagnosis date: ___/___/___ Illness duration: ___ days

Signs and Symptoms

Y N DK NA
 Diarrhea Maximum # of stools in 24 hours: _____
 Bloody diarrhea
 Abdominal cramps or pain
 Nausea
 Vomiting
 Fever Highest measured temp (°F): _____
 Oral Rectal Other: _____ Unk

Hospitalization

Y N DK NA
 Hospitalized at least overnight for this illness
 Hospital name _____
 Admit date ___/___/___ Discharge date ___/___/___
 Y N DK NA
 Died from illness Death date ___/___/___
 Autopsy Place of death _____

Predisposing Conditions

Y N DK NA
 Immunosuppressive therapy or disease

Laboratory

Collection date ___/___/___
 Source _____
 P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

Clinical Findings

Y N DK NA
 Bacteremia
 Sepsis syndrome
 Septic arthritis
 Reactive arthritis

P N I O NT

Salmonella culture (clinical specimen)
 Salmonella serotype: _____
 PFGE result: _____
 Detection of Salmonella using a non-culture based method [Suspect]

NOTES

Antimicrobial Treatment

Y N DK NA
 Antibiotics: _____

Montana Department of Public Health and Human Services	Case Name:
INFECTION TIMELINE: All questions refer to the 1 – 5 days before onset.	
Days from onset:	Exposure period
Calendar dates:	-5 days -1 days
	Onset
	Contagious period (weeks)

EXPOSURES

EXPOSURE (Refer to dates above)	Case knows anyone with similar symptoms <input type="checkbox"/> household contact <input type="checkbox"/> daycare <input type="checkbox"/> friend <input type="checkbox"/> other attendees at common event <input type="checkbox"/> lab confirmed case <input type="checkbox"/> Other, specify _____	Details:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Epidemiologic link to a confirmed human case	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Contact with diapered or incontinent child or adult	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Visited, lived or worked in a residential facility	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Travel out of the state, out of the country, or outside of usual routine	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Were you on any kind of special or restricted diet for medical, weight loss, religious or other reasons?	If yes, describe:
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Any allergies that prevent you from eating: <input type="checkbox"/> Milk <input type="checkbox"/> Other dairy <input type="checkbox"/> Eggs <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree nuts <input type="checkbox"/> Fish <input type="checkbox"/> Soy <input type="checkbox"/> Wheat <input type="checkbox"/> Shellfish <input type="checkbox"/> Other _____	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Vegetarian or vegan diet	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Known contaminated food product? Specify: _____	

Sources of food

Sources of food: (check all that apply)	List Store/Retail Names & Locations:
<input type="checkbox"/> Grocery store or supermarkets <input type="checkbox"/> Warehouse stores (e.g., Costco, Sam's Club) <input type="checkbox"/> Small markets, mini marts & convenience stores <input type="checkbox"/> Deli counters <input type="checkbox"/> Ethnic specialty markets (Mexican, Asian or Indian) <input type="checkbox"/> Health food stores or Co-ops <input type="checkbox"/> Fish or meat specialty shops (butcher's shop, etc.) <input type="checkbox"/> Farmer's markets, roadside stands, open-air markets, or food purchased directly from a farm <input type="checkbox"/> School or other institutional setting <input type="checkbox"/> Food samples in stores <input type="checkbox"/> Other, specify: _____	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Group meal, (e.g., potluck, reception)

Foods consumed outside the home (including restaurants, schools, etc.)

Date/Time of Meal	Restaurant/School/Facility Name & Location	Meal description

Montana Department of Public Health and Human Services	Case Name: _____
INFECTION TIMELINE: All questions refer to the 1 – 5 days before onset.	
Days from onset:	Exposure period
Calendar dates:	-5 days -1 days
_____	_____
	Onset Contagious period (weeks)

Meat

<p>Y N DK NA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed any beef <input type="checkbox"/> Ground beef <input type="checkbox"/> Steak <input type="checkbox"/> Stew <input type="checkbox"/> Roast</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed any other red meat <input type="checkbox"/> Lamb <input type="checkbox"/> Goat <input type="checkbox"/> Pork <input type="checkbox"/> Wild Game <input type="checkbox"/> Other _____ If so, how prepared: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed undercooked red meat (which one(s))?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Handled any raw red meat, even if you did not eat it <input type="checkbox"/> Beef <input type="checkbox"/> Lamb <input type="checkbox"/> Goat <input type="checkbox"/> Venison <input type="checkbox"/> Other _____ Meat was: <input type="checkbox"/> Ground <input type="checkbox"/> Steak <input type="checkbox"/> Stew <input type="checkbox"/> Roast</p>	<p><i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____ If steak, type/cut: _____</p>
<p>Y N DK NA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed any chicken <input type="checkbox"/> Whole chicken <input type="checkbox"/> Parts <input type="checkbox"/> Fried <input type="checkbox"/> Nuggets</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed any other poultry meat <input type="checkbox"/> Turkey <input type="checkbox"/> Duck <input type="checkbox"/> Wild Fowl <input type="checkbox"/> Other _____ If so, how prepared: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed undercooked poultry meat (which one(s))?</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Handled any raw poultry, even if you did not eat it <input type="checkbox"/> Chicken <input type="checkbox"/> Turkey <input type="checkbox"/> Duck <input type="checkbox"/> Wild Fowl <input type="checkbox"/> Other _____</p>	<p><i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed any other meats <input type="checkbox"/> Deli meats: _____ <input type="checkbox"/> Hot Dogs <input type="checkbox"/> Pepperoni <input type="checkbox"/> Salami <input type="checkbox"/> Bologna <input type="checkbox"/> Italian-style meats <input type="checkbox"/> Dried meat strips or jerky</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deli meat products? Specify _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Meat salads? Specify _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frozen meat products? Specify _____</p>	<p><i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed any seafood <input type="checkbox"/> Tuna <input type="checkbox"/> Salmon <input type="checkbox"/> Shrimp <input type="checkbox"/> Shellfish <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Consumed any eggs <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Undercooked eggs</p>	<p><i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____</p>

Raw/Unpasteurized Products

<p>Y N DK NA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Raw milk • Type: <input type="checkbox"/> Cow <input type="checkbox"/> Goat <input type="checkbox"/> Other, specify _____</p>	<p><i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____ Is there product remaining? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cheese made from raw milk • Type: <input type="checkbox"/> Queso fresco <input type="checkbox"/> Queso blanco <input type="checkbox"/> Other, specify _____</p>	<p><i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Artisanal or gourmet cheese • Type: _____</p>	<p><i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized juice or cider • Type: _____</p>	<p><i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____</p>
<p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Other unpasteurized product? • Type: <input type="checkbox"/> Kefir <input type="checkbox"/> Ice cream <input type="checkbox"/> Other, specify _____</p>	<p><i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____</p>

INFECTION TIMELINE:

All questions refer to the 1 – 5 days before onset.

Days from onset:	Exposure period		Onset	Contagious period (weeks)
	-5 days	-1 days		
Calendar dates:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Fruit

Y N DK NA Fresh fruit

- Type: Berries Pre-cut fruit Whole fruit
 Watermelon Cantaloupe Honeydew
 Tropical (e.g. pineapple, kiwi, mango)
 Other, specify _____
- Specify:

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____

Frozen fruit
 • Specify:

Leafy Greens

Y N DK NA Iceberg lettuce

- Any Iceberg lettuce eaten at home? Y N Unk
- In what form(s) was the Iceberg lettuce purchased?
 Pre-packaged/bagged Loose/Head Both
- Any Iceberg lettuce outside the home? Y N Unk
- Form of Iceberg lettuce outside home:
 On burger/sandwich/wrap Salad/salad bar
 Both Other

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____

Iceberg outside the home details:

Romaine lettuce

- Any Romaine lettuce eaten at home? Y N Unk
- In what form(s) was the Romaine lettuce purchased?
 Pre-packaged/bagged Loose/Head Both
- Any Romaine lettuce outside the home? Y N Unk
- Form of Romaine lettuce outside home:
 On burger/sandwich/wrap Salad/salad bar
 Both Other

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____

Romaine outside the home details:

Spinach

- Any spinach eaten at home? Y N Unk
- In what form(s) was the spinach purchased?
 Pre-packaged/bagged Loose/Head Both
- Any spinach eaten outside the home? Y N Unk
- Form of spinach outside home:
 On burger/sandwich/wrap Salad/salad bar
 Both Other

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____

Spinach outside the home details:

Other leafy greens
 • Type: Mesclun Red leaf
 Spring mix Butter
 Radicchio Baby salad greens
 Herb mix Kale
 Other, specify _____

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____
 Packaging type: Pre-packaged Loose/Head
 Other, specify _____ Unknown

Nuts

Y N DK NA Any nuts

- Type: Nuts Nut Butter Peanut Butter
 Peanuts Hazelnuts Cashews
 Pistachios Pine Nuts
 Other, specify _____

Purchase information:
 Facility and location: _____
 Brand: _____
 Date bought: _____

Montana Department of Public Health and Human Services	Case Name:			
INFECTION TIMELINE:				
All questions refer to the 1 – 5 days before onset.	<i>Days from onset:</i>	<i>Exposure period</i>	<i>Onset</i>	<i>Contagious period</i> <i>(weeks)</i>
	-5 days	-1 days		
	<i>Calendar dates:</i>			

Vegetables					
Y	N	DK	NA	Sprouts • Type: <input type="checkbox"/> Alfalfa <input type="checkbox"/> Clover <input type="checkbox"/> Bean <input type="checkbox"/> Broccoli <input type="checkbox"/> Daikon radish <input type="checkbox"/> Other, specify _____	<i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fresh herbs • Type: <input type="checkbox"/> Basil <input type="checkbox"/> Cilantro <input type="checkbox"/> Parsley <input type="checkbox"/> Sage <input type="checkbox"/> Thyme <input type="checkbox"/> Dill <input type="checkbox"/> Other, specify _____	<i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fresh vegetables • Type: <input type="checkbox"/> Tomatoes <input type="checkbox"/> Cucumbers <input type="checkbox"/> Celery <input type="checkbox"/> Guacamole <input type="checkbox"/> Salsa <input type="checkbox"/> Peppers <input type="checkbox"/> Other, specify _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other fresh vegetables • Specify: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other frozen vegetables • Specify: _____	<i>Details</i>

Water					
Y	N	DK	NA	Source of drinking water known • Type: <input type="checkbox"/> Individual well <input type="checkbox"/> Shared well <input type="checkbox"/> Public water system <input type="checkbox"/> Bottled water <input type="checkbox"/> Other: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drank untreated/unchlorinated water (e.g. surface, well)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational water exposure • Type: <input type="checkbox"/> Natural water <input type="checkbox"/> Pools, spas, fountain, water park <input type="checkbox"/> Both <input type="checkbox"/> Other: _____	

Animal Contact					
Y	N	DK	NA	Any contact with animals? • Type: <input type="checkbox"/> Cow/calf <input type="checkbox"/> Goat <input type="checkbox"/> Sheep <input type="checkbox"/> Deer <input type="checkbox"/> Horse/pony <input type="checkbox"/> Donkey <input type="checkbox"/> Any Reptile <input type="checkbox"/> Snake <input type="checkbox"/> Turtle <input type="checkbox"/> Lizard <input type="checkbox"/> Hedgehog <input type="checkbox"/> Parrot <input type="checkbox"/> Live poultry <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Visit or work at any of the following locations, even if no direct animal contact? <input type="checkbox"/> Live on farm <input type="checkbox"/> Dairy farm <input type="checkbox"/> Petting zoo <input type="checkbox"/> Slaughter house <input type="checkbox"/> Veterinary <input type="checkbox"/> Fair <input type="checkbox"/> 4-H event/ show <input type="checkbox"/> Shelter <input type="checkbox"/> Pet shop <input type="checkbox"/> Hunting <input type="checkbox"/> Research <input type="checkbox"/> Other _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household member works with animals • Specify: _____	<i>Details</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Raw pet food / treats	<i>Purchase information:</i> Facility and location: _____ Brand: _____ Date bought: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apply compost/manure	

