



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

Case ID _____

Outbreak-related

LHJ Cluster #: _____

Campylobacteriosis

Reported to DPHHS: Date ___/___/___

Classification: Confirmed Probable
 Suspect

Method: Lab Clinical

Epi Link: _____

DPHHS Outbreak #: _____

County _____

REPORT SOURCE

Initial report date ___/___/___

Reporter (check all that apply)

Lab Hospital HCP

Public health agency Other

OK to talk to case? Yes No Don't know

Investigation start date: ___/___/___

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact Parent/guardian Spouse Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____

Gender F M Other Unk

Ethnicity Hispanic or Latino

Not Hispanic or Latino

Race (check all that apply)

Amer Ind/AK Native Asian

Native HI/other PI Black/Afr

Amer

White

Other

Patient could not be interviewed

CLINICAL INFORMATION

Onset date: ___/___/___ Calculated Diagnosis date: ___/___/___ Illness duration: _____ days

Signs and Symptoms

Y N ? 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 ? NA

Hospitalized for this illness

Hospital name _____

Admit date ___/___/___ Discharge date ___/___/___

Died from illness Death date ___/___/___

Autopsy Place of death _____

Predisposing Conditions

Y N ? NA

Underlying illness, specify: _____

Immunosuppressive therapy

Laboratory

Collection date ___/___/___

Source _____

P = Positive O = Other
N = Negative NT = Not Tested
I = Indeterminate

P N I O NT

Campylobacter culture (clinical specimen)

Campylobacter species: _____

Clinical Findings

Y N ? NA

Guillain-Barre syndrome

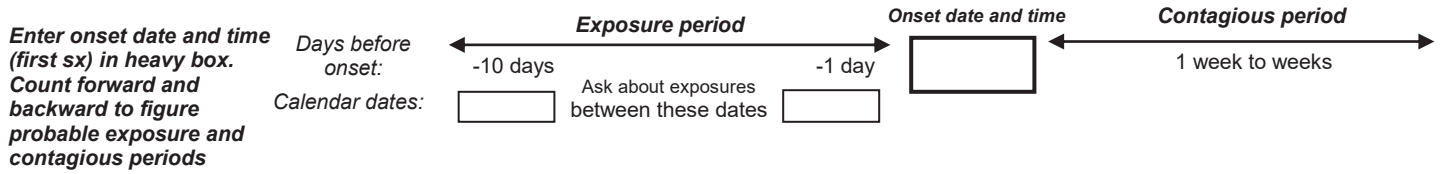
Reactive arthritis

NOTES

INFECTION TIMELINE: Get precise answers for onset times if at all possible. Without a date **and time**, it's hard to make a decent epi curve or to calculate incubation times. Estimates are OK. Prompt as needed: "What is your best guess of the time?" Don't let them get away with vague stuff like "morning" or "some time after midnight." Be careful with times such as "midnight" or early morning hours—which day do they mean? For example, by "2 am Friday night," do they really mean Saturday morning? Keep probing until it is unambiguous, and then write down what they mean—not just what they say. Midnight will be considered as the **end of the day** (e.g., 11:59 pm).

EXPOSURE HISTORY: Ask about travel, the kinds of foods eaten, places where case might have eaten in the 8 days before onset as determined in timeline below.

INFECTION TIMELINE



EXPOSURE (Refer to dates above)

LEAD-IN QUESTIONS

Y N ? NA

Did you travel? Out of: County State Country

Dates/Locations: _____

Does case know anyone with similar symptoms? Is contact with lab confirmed case? Was contact: Casual Household Sexual Diapered child Diapered adult Other: _____

FOOD EXPOSURE QUESTIONS

Y N ? NA

Any poultry, Undercooked poultry, Handled raw poultry, Any eggs, Raw or runny eggs, Home-made eggnog, Ice cream, Raw dough or batter, Raw fruits or vegetables, Any sprouts (e.g. alfalfa, clover, bean), Unpasteurized milk (cow), Unpasteurized cheese (e.g. soft cheese from raw milk, queso fresco or food made with these cheeses), Juices or ciders Type: _____ Unpasteurized: Y N ? NA, Known contaminated food product, Group meal (e.g. potluck, reception), Meal at campground: NAME _____

Y N ? NA

Food from restaurants Restaurant name/Location: _____

Congregate living Type: Long term care facility Shelter Barracks Dormitory Other: _____

WATER/ANIMAL EXPOSURE

Y N ? NA

Home source of drinking water Individual well Shared well Public water system Bottled water Other: _____, Drank untreated/unchlorinated water (e.g. surface, well), Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains), Did you drink water from a campground? Name/location: _____, Case or household member lives or works on farm or dairy, Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse) Specify animal: _____, Exposure to pets Was the pet sick: Y N ? NA, Raw pet food or dried pet treats, Zoo, farm, fair, or pet shop visit, Livestock or farm poultry chicks ducks other: _____, Any contact with animal at home or elsewhere, Cat or kitten

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? In MT (County: _____) US but not MT Not in US Unk

PATIENT PROPHYLAXIS/TREATMENT

PUBLIC HEALTH ISSUES		PUBLIC HEALTH ACTIONS	
<p>Y N ? NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed as food worker Where? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Non-occupational food handling (e.g. potlucks, receptions) during contagious period</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed as health care worker</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed in child care or preschool</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Attends child care or preschool</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Household member or close contact in sensitive occupation or setting (HCW, child care, food)</p>		<p><input type="checkbox"/> Initiate trace-back investigation</p> <p><input type="checkbox"/> Hygiene education provided</p> <p><input type="checkbox"/> Restaurant inspection</p> <p><input type="checkbox"/> Child care inspection</p> <p><input type="checkbox"/> Investigation of raw milk/dairy</p> <p><input type="checkbox"/> Other: specify _____</p>	
Investigator _____ Phone/email: _____		Investigation complete date ___/___/___	
Local health jurisdiction _____		Record complete date ___/___/___	