



Send completed forms to DOH Communicable Disease Epidemiology
Fax: 206-418-5515

LHJ Use ID _____

Reported to DOH Date ___/___/___

LHJ Classification Confirmed
 Probable

By: Lab Clinical
 Other: _____

Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____

Date Received ___/___/___

DOH Classification

Confirmed

Probable

No count; reason:

Salmonellosis

(Do not use for Typhoid Fever)

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

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: _____

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

CLINICAL INFORMATION

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 for this illness

Hospital name _____

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

Y N DK NA

Died from illness Death date ___/___/___

Autopsy

Predisposing Conditions

Y N DK NA

Immunosuppressive therapy or disease

Laboratory

Collection date ___/___/___

Y N DK NA

Salmonella isolated (clinical specimen)

Salmonella serotype: _____

PFGE result: _____

Clinical Findings

Y N DK NA

Bacteremia

Sepsis syndrome

Septic arthritis

Reactive arthritis

NOTES

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:	Exposure period		o n s e t	Contagious period	
	-5	-1		weeks	
Calendar dates:					

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><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 Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case knows anyone with similar symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with lab confirmed case <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Needle use <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologic link to a confirmed human case</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with diapered or incontinent child or adult</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poultry Undercooked: <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>DK <input type="checkbox"/>NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Handled raw poultry</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eggs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Raw or runny eggs or food with raw eggs (e.g. home-made eggnog or ice cream, raw dough or batter)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Raw fruits or vegetables</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sprouts (e.g. alfalfa, clover, bean)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized milk (cow)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized dairy products (e.g. soft cheese from raw milk, queso fresco or food made with these cheeses)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Juices or ciders Type: _____ Unpasteurized: <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>DK <input type="checkbox"/>NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Known contaminated food product</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Group meal (e.g. potluck, reception)</p> <p><input type="checkbox"/> Patient could not be interviewed</p> <p><input type="checkbox"/> No risk factors or exposures could be identified</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Food from restaurants Restaurant name/Location: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Source of home drinking water known <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: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Drank untreated/unchlorinated water (e.g. surface, well)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case or household member lives or works on farm or dairy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Work with animals or animal products (e.g. research, veterinary medicine, slaughterhouse)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Exposure to pets Was the pet sick: <input type="checkbox"/>Y <input type="checkbox"/>N <input type="checkbox"/>DK <input type="checkbox"/>NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Zoo, farm, fair, or pet shop visit</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Livestock or farm poultry</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any contact with animal at home or elsewhere</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cat or kitten</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Reptile (e.g. lizard, snake, turtle)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Any type of sexual contact with others during exposure period # female sexual partners: _____ # male sexual partners: _____</p>
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Most likely exposure/site: _____ Site name/address: _____

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

PATIENT PROPHYLAXIS/TREATMENT

PUBLIC HEALTH ISSUES

Y N DK NA

Employed as food worker

Non-occupational food handling (e.g. potlucks, receptions) during contagious period

Employed as health care worker

Employed in child care or preschool

Attends child care or preschool

Household member or close contact in sensitive occupation or setting (HCW, child care, food)

Outbreak related

PUBLIC HEALTH ACTIONS

Exclude from sensitive occupations (HCW, food, child care) or situations until 2 negative stools

Culture close contacts in sensitive occupations (HCW, food, child care) or situations (child care) regardless of symptom

Initiate trace-back investigation

Hygiene education provided

Restaurant inspection

Child care inspection

Investigation of raw milk/dairy

Other: specify _____

Investigator _____ Phone/email: _____ Investigation complete date ____ / ____ / ____

Local health jurisdiction _____