Washington State Department of Health

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

Typhoid Fever

County

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:***

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: ____
☐	☐	☐	☐	**Constipation**
☐	☐	☐	☐	Abdominal cramps or pain
☐	☐	☐	☐	**Loss of appetite (anorexia)**
☐	☐	☐	☐	**Fever** Highest measured temp (^{o}F): _____ ☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk
☐	☐	☐	☐	Night sweats
☐	☐	☐	☐	Headache
☐	☐	☐	☐	Malaise
☐	☐	☐	☐	Cough Onset date:
☐	☐	☐	☐	**Nonproductive cough**

Predisposing Conditions

Y	N	DK	NA	
☐	☐	☐	☐	Previously known typhoid carrier
☐	☐	☐	☐	Immunosuppressive therapy or disease
☐	☐	☐	☐	Underlying illness Specify: _____

Clinical Findings

Y	N	DK	NA	
☐	☐	☐	☐	**Rash - rose spots**
☐	☐	☐	☐	Splenomegaly

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

Vaccination

Y	N	DK	NA	
☐	☐	☐	☐	Typhoid vaccine in past 5 years Date of last vaccination (mm/yyyy): ____/_____ Typhoid vaccine type: _____

Laboratory

Collection date ___/___/___

Y	N	DK	NA	
☐	☐	☐	☐	**S. typhi isolation (clinical specimen, e.g. blood, stool)**

NOTES

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

Washington State Department of Health **Case Name:** _____

INFECTION TIMELINE

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

	Exposure period		onset	***Contagious period***
Days from onset:	-30	-3		weeks
Calendar dates:				

EXPOSURE (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
  Out of: ☐ County ☐ State ☐ Country
  Dates/Locations:
- ☐ ☐ ☐ ☐ Case knows anyone with similar symptoms
- ☐ ☐ ☐ ☐ **Epidemiologic link to a confirmed human case**
- ☐ ☐ ☐ ☐ Contact with lab confirmed case
  ☐ Household ☐ Sexual
  ☐ Needle use ☐ Other: _____
- ☐ ☐ ☐ ☐ Contact with known typhoid carrier
  ☐ Household ☐ Sexual
  ☐ Needle use ☐ Other: _____
- ☐ ☐ ☐ ☐ Contact with diapered or incontinent child or adult
- ☐ ☐ ☐ ☐ Refrigerated, prepared food (e.g. dips, salsas, salads, sandwiches)
- ☐ ☐ ☐ ☐ Unpasteurized milk (cow)

Y N DK NA

- ☐ ☐ ☐ ☐ Known contaminated food product
- ☐ ☐ ☐ ☐ Group meal (e.g. potluck, reception)
- ☐ ☐ ☐ ☐ Food from restaurants

Restaurant name/Location: _____
_____

- ☐ ☐ ☐ ☐ Source of home drinking water known
  ☐ Individual well ☐ Shared well
  ☐ Public water system ☐ Bottled water
  ☐ Other: _____
- ☐ ☐ ☐ ☐ Drank untreated/unchlorinated water (e.g. surface, well)
- ☐ ☐ ☐ ☐ Employed in laboratory
- ☐ ☐ ☐ ☐ Contact with recent foreign arrival
  ☐ Household ☐ Sexual
  ☐ Needle use ☐ Other: _____
  Specify country: _____
- ☐ ☐ ☐ ☐ Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____

☐ **Patient could not be interviewed**
☐ **No risk factors or exposures could be identified**

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 in child care or preschool
- ☐ ☐ ☐ ☐ Attends child care or preschool
- ☐ ☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___
  Agency and location: _____
  Type of donation: _____
- ☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

- ☐ Exclude individuals from sensitive occupation (HCW, child care) or situation (child care) until 3 negative stools
- ☐ Consider excluding symptomatic contacts from sensitive occupations (HCW, food, child care) or situations (child care) until 2 negative stools
- ☐ Notify others sharing exposure
- ☐ Hygiene education provided
- ☐ Child care inspection
- ☐ Follow-up of household members
- ☐ Work or child care restriction for household member
- ☐ Notify blood or tissue bank
- ☐ Other, specify: _____

NOTES

Investigator _____ **Phone/email:** _____ **Investigation complete date** ___/___/___

Local health jurisdiction _____

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