Tennessee Department of Health

FoodNet Case Report

Please fill this form out as complete as possible. Anything that appears in **red** is not available for data entry into NEDSS. However, you may find those fields helpful in your investigation. Do not forget to complete the appropriate disease-specific supplement form.

Demographics

Last Name: _____ **First:** _____ **Middle:** _____ **DOB:** ____/____/_____

Reported Age: _____ □ Days □ Months □ Years **Sex:** □ Male □ Female □ Unknown

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Ethnicity: □ Hispanic □ Not Hispanic **Race:** □ American Indian / Alaskan □ Asian □ Black / African American □ Hawaiian / Pacific Islander □ White □ Other (_____)

Employer/School/Daycare: _____ **Occupation:** _____

Lab Report

Reporting Facility: _____ **Ordering Facility:** _____

Ordering Provider: _____ **Phone Number:** _____

Jurisdiction: □ East Tennessee □ West Tennessee □ Jackson/Madison □ Mid-Cumberland □ Upper Cumberland □ Memphis/Shelby □ Northeast □ Nashville/Davidson □ Sullivan □ South Central □ Chattanooga/Hamilton □ Out of Tennessee □ Southeast □ Knoxville/Knox □ Unassigned

Lab Report Date: ____/____/_____
Date Received by Public Health: ____/____/_____
Date Specimen Collected: ____/____/_____

Specimen Source: □ Blood □ CSF □ Stool □ Urine □ Other _____ □ Unknown _____

Resulted Test

Culture Methods

□ *Campylobacter* sp identified
□ *Cryptosporidium* sp
□ *Cyclospora* identified
□ *E. coli* identified
□ *Listeria* sp identified
□ *Salmonella* sp identified
□ *Shigella* sp identified
□ *Yersinia* identified
□ *Vibrio* sp identified

Non-Culture Methods

□ *Campylobacter* test, EIA
□ positive □ indeterminate
□ negative

□ *Campylobacter* test, PCR
□ positive □ indeterminate
□ negative

□ *Cryptosporidium*
□ acid-fast stain □ DFA □ EIA
□ rapid cartridge □ PCR □ Other

□ *E. coli* Shiga toxin test, EIA
□ stx1 □ stx1 & stx2
□ stx2 □ undifferentiated

□ *E. coli* Shiga toxin test, PCR
□ stx1 □ stx1 & stx2
□ stx2 □ undifferentiated

□ Microorganism identified, by PCR

Organism

Investigation

Investigation Summary

Investigation Start Date: ____/____/_____
Investigation Status: □ Open □ Closed
Investigator: _____
Date Assigned to Investigation: ____/____/_____

Reporting Source

Date of Report: ____/____/_____
Reporting Source: _____
Earliest Date Reported to County: ____/____/_____
Reporter: _____

Clinical Information

Physician: _____ **Physician's Phone:** _____

Was the patient hospitalized for this illness?: □ Yes □ No □ Unknown
Hospital: _____
Admission Date: ____/____/_____ **Discharge Date:** ____/____/_____
***If patient not hospitalized*, Diagnosis Date:** ____/____/_____

Is the patient pregnant?: □ Yes □ No □ Unknown **Did the patient die from this illness?:** □ Yes □ No □ Unknown

Epidemiologic Information

Is this patient associated with a daycare facility?: □ Yes □ No □ Unknown
***If yes*, name of daycare:** _____

Is this patient a food handler?: □ Yes □ No □ Unknown
***If yes*, name of restaurant/facility:** _____

Is this case part of an outbreak?: □ Yes □ No □ Unknown
***If part of a multistate cluster or outbreak*, list CDC cluster code:** _____

Transmission Mode: □ Foodborne □ Waterborne □ Zoonotic □ Indeterminate □ Other _____

Case Status: □ Confirmed □ Probable □ Suspect

Food Core Questions (For Administrative Use Only):

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Was the case interviewed by public health? □ Yes □ No □ Unknown
***If no*, was an attempt made?** □ Yes □ No □ Unknown
Date of first interview attempt: ____/____/_____
Date of interview: ____/____/_____
Interviewer's Name: _____

Was a food history obtained? □ Yes □ No □ Unknown
Was the case entered into NEDSS? □ Yes □ No □ Unknown
Date entered into NEDSS: ____/____/_____
Data Entry Person's Name: _____
Other Notes: _____

SYMPTOM HISTORY

Date/Time of Illness Onset: ____/____/_____ ____:____ □ AM □ PM **First Symptom:** _____

Symptoms: (Check all that apply)

□ Abdominal cramps □ Anorexia □ Backache □ Bloody diarrhea □ Bullae
□ Cellulitis □ Chills □ Constipation □ Diarrhea □ Fatigue
□ Fever (Max)____ °F □ Headache □ Muscle aches □ Nausea □ Shock
□ Vomiting □ Weight loss □ Reactive Arthritis □ Other _____

IF YES TO DIARRHEA,

Date/Time of Diarrhea Onset:
____/____/_____ ___:___ □ AM □ PM

Maximum number of stools in a 24-hour period: _____

Are you still experiencing symptoms?
□ Yes □ No □ Unknown

***If no longer experiencing symptoms*, how long did they last?:**
_____ □ Minutes □ Hours □ Days

IF YES TO VOMITING,

Date/Time of Vomiting Onset:
____/____/_____ ___:___ □ AM □ PM

Maximum number of vomiting episodes in a 24-hour period: _____

Are you still experiencing symptoms?
□ Yes □ No □ Unknown

***If no longer experiencing symptoms*, how long did they last?:**
_____ □ Minutes □ Hours □ Days

OTHER ILLNESS INFORMATION

Date/Time of Recovery:
____/____/_____ ___:___ □ AM □ PM

Duration of Illness:
_____ □ Minutes □ Hours □ Days

***If known*, Date/Time of Exposure:**
____/____/_____ ___:___ □ AM □ PM

Location:
_____
_____
_____

TRAVEL HISTORY

Did patient travel prior to onset of illness? □ Yes □ No □ Unknown

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Type: □ Domestic □ International **Destination 1:** _____ _____ **Mode of travel:** □ Airplane □ Bus □ Car □ Cruise □ Ship □ Train

Date of Arrival: ____/____/_____ **Date of Departure:** ____/____/_____

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Type: □ Domestic □ International **Destination 1:** _____ _____ **Mode of travel:** □ Airplane □ Bus □ Car □ Cruise □ Ship □ Train

Date of Arrival: ____/____/_____ **Date of Departure:** ____/____/_____

If more than 2 destinations, please specify here:

RELATED CASES

Does the patient know of any similarly ill persons (with diarrhea)?: □ Yes □ No □ Unknown

***If yes*, did the health department collect contact information about other similarly ill persons and investigate further?:** □ Yes □ No □ Unknown

Are there any other cases related to this one?: □ Yes, household □ Yes, outbreak □ No, sporadic □ Unknown

Provide names, onset dates, contact information and any other details for similarly ill persons or related cases:

FOODNET

FoodNet Case?: □ Yes □ No □ Unknown

TRANSFER HOSPITAL INFORMATION

Was the patient transferred from one hospital to another?: □ Yes □ No □ Unknown

***If yes*, specify name of the hospital to which the patient was transferred:** _____

SECOND HOSPITALIZATION

Was there a second hospitalization?: □ Yes □ No □ Unknown

***If yes*, Hospital Name:** _____
Admission Date: ____/____/_____
Discharge Date: ____/____/_____

IMMIGRATION

Did patient immigrate to the US within 7 days of specimen collection?: □ Yes □ No □ Unknown

CASE-CONTROL INFORMATION

In a case-control study? □ Yes □ No □ Unknown

OUTBREAK INFORMATION

Type of outbreak:

□ Animal contact □ Other
□ Environmental contamination other than food/water □ Person-to-person
□ Foodborne □ Waterborne
□ Indeterminate □ Unknown

CDC EFORS/NORS number? _____

AUDIT INFORMATION

Was the case found during an audit*? □ Yes □ No □ Unknown

Our FoodNet hospital visit constitutes an audit.