



FoodNet Case Report Form

The FoodNet Case Report Form should be used for Campylobacter, Cryptosporidium, Cyclospora, Listeria, Shigella, STEC, Vibrio and Yersinia. Please fill this form out as complete as possible. Do not forget to complete the appropriate disease-specific supplemental form.

Last Name: PSN1 TN01 CAS1 TN01 State Lab Accession #: First: Middle: DOB:

FOR ADMINISTRATIVE USE

FoodNet Case? Was the case found during an audit? Was the case interviewed by public health? Interviewer's Name: Was an exposure history obtained?

DEMOGRAPHICS

Reported Age: Sex: Street Address: City: County: State: Zip: Home Phone: Work Phone: Cell Phone: Did patient immigrate to the US within 7 days of specimen collection? In the past 7 days, has the patient lived/stayed overnight in any of the following locations? Ethnicity: Race: Employer/School: Occupation: Is this patient associated with a daycare facility? Is this patient a food handler?

LAB REPORT

Reporting Facility: Ordering Facility: Ordering Provider: Phone Number: Jurisdiction: Specimen Source:

Lab Report Date: Date Received by Public Health: Date Specimen Collected: ORGANISM IDENTIFIED TEST TYPE(S) CASE STATUS

OUTBREAK/CLUSTER

Is this case part of an outbreak? Type of Outbreak: CDC Cluster Code: CDC EFORS/NORS Number:

INVESTIGATION

Investigation Start Date: _____

Investigator: _____

Investigation Status: Open Closed

Date Assigned to Investigation: _____

SYMPTOM HISTORY

Date of Illness Onset: _____

First Symptom: _____

Symptoms: Diarrhea Bloody Diarrhea Constipation
 Vomiting Nausea Weight Loss
Check all that apply Fatigue Chills Fever (Max Temp: _____ °F)
 Headache Abdominal Cramps Muscle Aches
 Other: _____

If yes to diarrhea, date of diarrhea onset: _____

If yes to vomiting, date of vomiting onset: _____

As of today, are you still experiencing symptoms? Yes No Unknown

If recovered, date of recovery: _____

Duration of Illness: _____ Minutes Hours Days**CLINICAL INFORMATION/HOSPITALIZATION**

Was the patient hospitalized for this illness?

 Yes No Unknown

If yes, Hospital Name: _____

Admission Date: _____

Discharge Date: _____

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

If yes, specify the hospital to which the patient was transferred:

Was there a second hospitalization?

 Yes No Unknown

If yes, Hospital Name: _____

Admission Date: _____

Discharge Date: _____

During any part of the hospitalization, did the patient stay in and Intensive Care Unit (ICU) or a Critical Care Unit (CCU)?

 Yes No UnknownIs the patient pregnant? Yes No UnknownDid the patient die from this illness? Yes No Unknown**TRAVEL HISTORY**Did the patient travel prior to the onset of illness? Yes No Unknown

| Type | Destination | Date of Arrival | Date of Departure |
|--|-------------|-----------------|-------------------|
| <input type="checkbox"/> Domestic <input type="checkbox"/> International | | | |
| <input type="checkbox"/> Domestic <input type="checkbox"/> International | | | |
| <input type="checkbox"/> Domestic <input type="checkbox"/> International | | | |

Notes:

RELATED CASESDoes the patient know of any similarly ill persons (with diarrhea)? Yes No UnknownAre there any other cases related to this one? Yes, household Yes, outbreak No, sporadic Unknown

If yes, did the health department collect contact information about other similarly ill persons to investigate further?

 Yes No Unknown

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

Last Name: _____ First: _____ Middle: _____ DOB: ____/____/____
 PSN1 _____ TN01 CAS1 _____ TN01 State Lab Accession #: _____

| INFECTION TIMELINE | EXPOSURE PERIOD | | | | | | | COMMUNICABLE | |
|--|-----------------|----|----|----|----|----|----|--------------|-------|
| | days from onset | -7 | -6 | -5 | -4 | -3 | -2 | -1 | onset |
| | calendar dates | | | | | | | | weeks |
| Enter onset date in heavy box. Count back to calculate the probable exposure period. Ask about exposures between those dates. For <i>Campylobacter</i> , the exposure period is 7 days before illness onset. | | | | | | | | | |

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

These first questions are about exposures you may have had in the 7 days before you got sick. There are questions about various items, including animals, ill persons, water, special diets, special events, and various foods you may have come into contact with. For each of the questions, please answer yes, no, or may have.

| ANIMAL CONTACT — In the 7 days before illness | | Yes | No | May Have | Did Not Ask/Answer |
|--|--------|--------------------------|--------------------------|--------------------------|--------------------------|
| *1. Did you work at, live on, or visit a farm, ranch or petting zoo with animals? (circle which setting) | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1A. Where? | When? | | | | |
| *2. Did you come into contact with any: | | Yes | No | May Have | Did Not Ask/Answer |
| Cats? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dogs? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chicken/turkey? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Birds (non-poultry)? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other: | | | | | |
| Rodents/small mammals? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Reptile/amphibian? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cattle/goat/sheep? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Pig? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2A. Where did you come into contact with the animal(s)? | | Yes | No | May Have | Did Not Ask/Answer |
| When? | | | | | |
| *3. Did you come into any contact with animal feces or manure? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| *4. Did you come into contact with a pet that had diarrhea? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Did you have any contact with dry, canned, or frozen animal feed? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5A. Please describe: | | | | | |
| PERSON-TO-PERSON | | | | | |
| *1. Did one of your household members or another person you spend a lot of time with have diarrhea in the 7 days before you became ill? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1A. Who? | Where? | | | | |
| WATER | | | | | |
| *1. Do you use water from a private well as your primary source of drinking water? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| *2. Did you drink any water directly from a natural spring, lake, pond, stream, or river in the 7 days before illness? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| *3. Did you swim or wade in water from a natural setting (lake, river, pond, ocean, etc.) in the 7 days before illness? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| *4. Did you swim or wade in treated/chlorinated water (pool, hot tub, waterpark, fountain, etc.) 7 days before illness? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| FOOD PREFERENCES | | | | | |
| 1. Are you a vegetarian or vegan? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Before you became ill, were you on a special diet for medical, weight loss, religious, allergies or any other reason? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2A. Please describe: | | | | | |
| EVENTS/ RESTAURANTS — In the 7 days before illness... | | | | | |
| 1. Did you attend any special events (concerts, festivals, sporting events, meetings, religious gatherings, etc.)? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1A. What event(s)? | Where? | | | | |
| When? | | | | | |
| 2. Did you eat food prepared outside the home (restaurants, catered events, etc.)? | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2A. If yes or maybe ate out, which setting? (check all that apply) | | | | | |
| <input type="checkbox"/> Fast-food (order at counter) <input type="checkbox"/> Take-out or delivery food <input type="checkbox"/> Bakery <input type="checkbox"/> Other: _____ | | | | | |
| <input type="checkbox"/> Sit-down restaurant (order taken at table) <input type="checkbox"/> Catered event <input type="checkbox"/> Ice cream or dessert shop | | | | | |
| <input type="checkbox"/> Self-serve buffet <input type="checkbox"/> School or other institutional setting <input type="checkbox"/> Coffee or tea shop | | | | | |
| 2B. Name(s) and Address(es): | | Foods eaten: | | When? | |
| | | | | | |

These next questions are about where your food at home came from in the 7 days before you became ill.

SOURCES OF FOOD AT HOME

| <i>Did your food come from...</i> | Yes | No | May Have | Did Not Ask/Answer | Name(s) and Location(s) |
|---|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|
| 1. Grocery stores/supermarkets? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Warehouse stores? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Small markets/mini-marts? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Health food, "whole food" stores, co-ops? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Farmer's markets, roadside stands, farm? (including farm shares, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Other? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

The next section is about specific foods you may have eaten, grouped by category. For each food item, please answer yes, no, or may have eaten. The first category is meats, which includes whole meats or meats on a salad, sandwich, or in a prepared dish, etc.

| <i>In the 7 days before illness did you eat ...</i> | Yes | No | May Have | Did Not Ask/Answer | Variety, Type, or Brand | Location Purchased or Restaurant |
|---|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|----------------------------------|
| MEAT/POULTRY | | | | | | |
| *1. Any chicken or foods containing chicken? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *1A. Fresh chicken prepared at home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *1B. Frozen chicken prepared at home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *1C. Ground chicken prepared at home or outside the home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *1D. Chicken outside the home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *2. Any turkey or foods containing turkey? (including deli meat) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *2A. Ground turkey at home or outside the home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *2B. Turkey outside the home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *3. Did you or anyone in your household handle raw poultry? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *4. Any beef or foods containing beef? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *4A. Ground beef at home or outside the home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *4B. Undercooked or raw ground beef at home or outside the home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *4C. Beef outside the home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *4D. Any veal at home or outside the home ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *5. Did you or anyone in your household handle raw beef ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *6. Any pork or foods containing pork? (including deli meat, sausage, bacon, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *7. Any lamb or mutton? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *8. Any liver paté? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *8A. Raw or undercooked liver? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *9. Any fish or fish products? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *9A. Raw or undercooked fish? (sushi, sashimi, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *10. Any seafood ? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *10A. Raw or undercooked seafood? (crab, shrimp, oyster, clam, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *11. Did you or anyone in your household handle raw fish or seafood? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

These next questions are about eggs and dairy products.

| <i>In the 7 days before illness did you eat ...</i> | Yes | No | May Have | Did Not Ask/Answer | Variety, Type, or Brand | Location Purchased or Restaurant |
|---|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|----------------------------------|
| EGGS | | | | | | |
| *1. Any eggs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *1A. Eggs that were raw, soft-boiled, "runny", or "over-easy"? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *2. Any foods made with raw eggs? (cookie dough, homemade mayo, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *3. Eggs outside the home? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

| | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--|--|
| DAIRY | | | | | | |
| *1. Pasteurized cow's or goat's milk? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *2. Raw or unpasteurized milk? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 3. Yogurt? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 4. Ice cream? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 5. Cheese? (block, shredded, sliced, string cheese, cottage cheese, feta, parmesan, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *6. Soft cheese? (queso fresco, brie, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *7. Soft cheese made from raw milk? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 8. Other raw milk cheeses? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *9. Other unpasteurized dairy products? (yogurt, ice cream, etc. made from raw milk) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

These next questions are about fresh fruits. This includes whole fruits as well as cut fruits that may have been part of a salad, sandwich, or smoothie, etc. This does not include fruits that are canned or cooked.

| <i>In the 7 days before illness did you eat ...</i> | Yes | No | May Have | Did Not Ask/Answer | Variety, Type, or Brand | Location Purchased or Restaurant |
|--|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|----------------------------------|
| FRUITS | | | | | | |
| *1. Berries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 1A. Strawberries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 1B. Raspberries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 1C. Blueberries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 1D. Other berries? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *2. Cantaloupe? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *3. Watermelon? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 4. Other fruits? | | | | | | |
| *5. Any raw or unpasteurized juice or cider? (sometimes bought from a farm or orchard) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

*These next questions are about **fresh, raw** vegetables unless otherwise specified. This includes vegetables that are whole, cut/chopped, or a component of another food item.*

| <i>In the 7 days before illness did you eat ...</i> | Yes | No | May Have | Did Not Ask/Answer | Variety, Type, or Brand | Location Purchased or Restaurant |
|--|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|----------------------------------|
| VEGETABLES | | | | | | |
| *1. Lettuce? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *2. Spinach? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *3. Sprouts? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 4. Other greens? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *5. Tomatoes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 6. Other fresh vegetables? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| *7. Any fresh (not dried) herbs? (basil, cilantro, parsley, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

These next questions are about other foods that have not been asked about yet.

Other Foods

| <i>In the 7 days before illness did you eat ...</i> | Yes | No | May Have | Did Not Ask/Answer | Variety, Type, or Brand | Location Purchased or Restaurant |
|--|--------------------------|--------------------------|--------------------------|--------------------------|-------------------------|----------------------------------|
| 1. Any foods marketed for babies? (formula, store-bought baby food, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 2. Any powdered shake or meal products? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| 3. Other foods that feel relevant that have not already been covered? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |

This is the end of the food and exposure specific questions.

OTHER COMMENTS

Is there anything else you feel may be relevant that has not already been asked?

FOR INTERVIEWER USE ONLY

At the conclusion of the interview please...

- Answer any questions
- Exclude persons from sensitive populations until 2 negative stools (health care, food handler, day care)
- Thank the patient for their time
- Central Office staff:** contact regional or local health department if patient is from a sensitive population
- Provide hygiene and prevention education
- Notify the appropriate staff of potential outbreaks, events, or unusual information

INTERVIEWER COMMENTS

Blank area for interviewer comments.