FoodNet Case Report Form

Department of Health

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 no forget to complete the appropriate disease-specific supplemental form.

Clear Print

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

PSN1__ __ __ __ __ __ __**TN01** **CAS1**__ __ __ __ __ __ __**TN01** **State Lab Accession #:** _____

For Administrative Use

FoodNet Case? ☐ Yes ☐ No ☐ Unknown

Was the case found during an audit?* ☐ Yes ☐ No ☐ Unknown **FoodNet hospital visits constitutes an audit.**

Was the case interviewed by public health? ☐ Yes ☐ No ☐ Unknown **Date of first attempt:** _____

If no, was an attempt made? ☐ Yes ☐ No ☐ Unknown **Date of Interview:** _____

Interviewer's Name: _____

Was an exposure history obtained? ☐ Yes ☐ No ☐ Unknown

Demographics

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

Street Address: _____

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

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

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

In the past 7 days, has the patient lived/stayed overnight in any of the following locations? *(check all that apply)*

☐ Dormitory ☐ Long-term Care Facility/Rehabilitation Center ☐ Homeless Shelter ☐ Outdoors/Other structure not intended for housing

☐ Correctional Facility ☐ Other Communal Living: _____ ☐ None of the above ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Not Hispanic **Race:** ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ White ☐ Hawaiian / Pacific Islander ☐ Refused ☐ Other: _____

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

Is this patient associated with a daycare facility? ☐ Yes ☐ No ☐ Unknown

If yes, specify association: ☐ Attend daycare ☐ Work/volunteer at daycare ☐ Live with daycare attendee

If yes, name of daycare: _____

Is this patient a food handler? ☐ Yes ☐ No ☐ Unknown

If yes, name of restaurant/facility: _____

Lab Report

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

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

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

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

Lab Report Date: _____

Date Received by Public Health: _____

Date Specimen Collected: _____

Organism Identified

☐ Campylobacter ☐ Cryptosporidium ☐ Cyclospora ☐ Listeria ☐ Shigella ☐ STEC ☐ Vibrio ☐ Yersinia

Test Type(s)

☐ Culture ☐ PCR ☐ EIA ☐ Other:

Case Status

☐ Confirmed ☐ Probable ☐ Suspect

Outbreak/Cluster

Is this case part of an outbreak? ☐ Yes ☐ No ☐ Unknown **CDC Cluster Code:** _____

Type of Outbreak: **CDC EFORS/NORS Number:** _____

☐ Animal Contact ☐ Environmental Contamination Other than Food/Water ☐ Foodborne ☐ Indeterminate ☐ Person-to-Person ☐ Waterborne

☐ Other: _____

Clear Print

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

Check all that apply ☐ Vomiting ☐ Nausea ☐ Weight Loss

☐ 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 ☐ Unknown

Is the patient pregnant? ☐ Yes ☐ No ☐ Unknown

Did 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
☐ Domestic ☐ International			
☐ Domestic ☐ International			
☐ Domestic ☐ International			

Notes:

RELATED CASES

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

Are 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:

Tennessee Department of Health

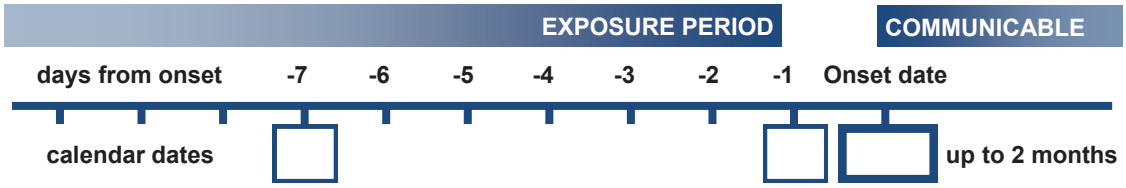
Cryptosporidiosis

Please fill this form out as completely 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 generic FoodNet Case Report form. Use date format mm/dd/yyyy throughout.

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

Infection Timeline

Enter the onset date in the heavy box. Count back to calculate the probable exposure period. Ask about exposures between those dates.



Possible Source(s) of Infection During Exposure Period

Yes	No	Unk		*If yes*, provide details (e.g. places, dates)
□	□	□	Consumed raw fruits or vegetables (e.g. berries, green salads)	
□	□	□	Consumed any raw or unpasteurized juices or ciders	
□	□	□	Consumed any raw or unpasteurized milk or dairy products	
□	□	□	Group meal (e.g. potluck, reception)	
□	□	□	Consumed food from restaurants (e.g. dining in, take-out, drive-thru, leftovers)	
□	□	□	Contact with diapered children	
□	□	□	Contact with any other persons having diarrhea	

Food Handler

Did patient work as a food handler after onset of illness? □ Yes □ No □ Unknown

What was the last date worked as a food handler after onset of illness? ____/____/_____

Where was the patient a food handler? _____

Drinking Water Exposure

What is the source of drinking water at home?

□ municipal, city or county
□ private well (used by 1 household)
□ common / community well (used by > 1 household)
□ bottled water
□ untreated surface water (e.g. spring, river, lake, creek, cistern)
□ other (specify) _____

What is the source of drinking water at work/school?

□ municipal, city or county
□ private well (used by 1 household)
□ common / community well (used by > 1 household)
□ bottled water
□ untreated surface water (e.g. spring, river, lake, creek, cistern)
□ other (specify) _____

Did the patient drink untreated water in the 7 days prior to onset of illness? □ Yes □ No □ Unknown

***If yes*, what was the source?** □ surface water (e.g. spring, river, lake, creek, cistern) □ well □ other _____

Recreational Water Exposure

Was there recreational water exposure in the 7 days prior to illness? □ Yes □ No □ Unknown

***If yes*, did the patient swallow any water from these exposures?** □ Yes □ No □ Unknown

What was the recreational water type?

□ natural hot spring
□ hot tub / whirlpool / Jacuzzi / spa
□ interactive fountain / splash pad
□ lake / pond / river / stream
□ ocean
□ recreational water park
□ swimming / wading pool
□ other (specify) _____

Name or location of water exposure: _____

Animal Contact

Did the patient visit or live on a farm? □ Yes □ No □ Unknown

Did the patient visit a live animal exhibit (petting zoo, fair, etc.)? □ Yes □ No □ Unknown

Did the patient come in contact with any animals? □ Yes □ No □ Unknown

***If yes*, type of animal:** □ Goat □ Cow □ Sheep □ Dog □ Cat
□ Rodent □ Turtle □ Lizard □ Chicken □ Turkey
□ Other bird □ Other mammal □ Other reptile □ Other amphibian

***If other bird, mammal, reptile* or *amphibian*, please specify:** _____

Name or location of animal contact: _____

Did the patient acquire a pet prior to onset of illness? □ Yes □ No □ Unknown

Did the patient come into contact with animal waste or manure? □ Yes □ No □ Unknown

Underlying Conditions

Does the patient have any underlying conditions (e.g. AIDS, diabetes)?: □ Yes □ No □ Unknown

***If yes*, specify:** _____

Patient Prophylaxis/Treatment

Was the patient treated with any medications for this illness? □ Yes □ No □ Unknown

***If yes*, specify type, dose and dates:** _____

Summary of Follow-Up

- □ **Exclude from sensitive occupations (e.g. HCW, food, daycare) or situations until symptoms have resolved**
- □ **Culture close contacts in sensitive occupations (e.g. HCW, food, daycare) or situations regardless of symptoms**
- □ **Initiate traceback investigation**
- □ **Hygiene education provided**
- □ **Restaurant inspection**
- □ **Daycare inspection**
- □ **Investigation of raw milk / dairy**
- □ **Other (specify)** _____

Alternate Contact Information

Last Name: _____ **First:** _____ **Relationship:** □ Parent □ Spouse □ Household Member □ Friend

Phone Number: _____ □ Other (specify) _____

Comments

_____

_____

_____

CryptoNet and Laboratory Information (For Administrative Use Only)

Specimen Status: Untreated: □ Fresh □ Frozen
Treated: □ Cary-Blair □ Formalin □ KCr_2O_7 □ PVA-Cu □ PVA-LV □ PVA-Zn □ TotalFix

Was specimen tested for *Cryptosporidium*? □ Yes (*complete table below*) □ No

Test Type (check all that apply)	Test Brand	Lot Number	Result
□ Acid-fast			
□ DFA			
□ EIA			
□ GI or Enteric Panel			
□ IC			
□ PCR			
□ Other (specify)			

State Case Lab ID: _____

State Case Epi ID: _____

NNDS Case ID: _____

NORS State ID: _____

CryptoNet Submission Date: _____

Lab Coordinator: _____

Epi Coordinator: _____