TN

Shigellosis Case Report Form

Please fill this form out as completely as possible. This form includes all the necessary information from both the FoodNet Case Report Form and *Shigella* Disease-Specific Form. Any information not available for NBS data entry may be useful in your investigation.

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
Was the case interviewed by public health? ☐ Yes ☐ No ☐ Unknown
***If no*, was an attempt made?** ☐ Yes ☐ No ☐ Unknown
Was an exposure history obtained? ☐ Yes ☐ No ☐ Unknown

**Our FoodNet hospital visit constitutes an audit.*
Date of interview completion: ______________
Date of first interview attempt: ______________
Interviewer's Name: ________________________

Demographics

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

Ethnicity: ☐ Hispanic ☐ Not Hispanic
Race: ☐ American Indian / Alaskan ☐ Asian ☐ Black / African American ☐ Refused to answer ☐ Hawaiian / Pacific Islander ☐ White ☐ Other: ______________

Street Address: ____

City: __________________________________ **County:** __________________________ **State:** ________________ **Zip:** ____________

Home Phone: __________________________ **Work Phone:**___________________________ **Cell Phone:** __________________________

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

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

☐ Dormitory ☐ Long-term Care Facility/Rehab Center ☐ Homeless Shelter ☐ Outdoors/Other structure not intended for housing ☐ Unknown
☐ Correctional Facility ☐ Other communal living: ____ ☐ **None of the above**

Employer/School: ____ **Occupation:** ___________________________

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

***If yes*, specify the association**: *(check all that apply)* ☐ Attend daycare ☐ Work/volunteer at daycare ☐ Live with daycare attendee

***If yes,* daycare name**: ___________________________________

Is this patient a food handler? ☐ Yes ☐ No ☐ Unknown ***If yes*, establishment name**: _________________________________

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	☐ Knoxville/Knox
☐ Jackson/Madison	☐ Memphis/Shelby	☐ Sullivan	☐ Out of Tennessee	☐ Unassigned

Lab Report Date: ______________
Date Received by Public Health: ______________
Date Specimen Collected: ______________

Specimen Source:
☐ Blood ☐ Stool ☐ Urine ☐ Unknown ☐ Other: ______________
Test Type: ☐ PCR ☐ EIA ☐ Culture ☐ Other: ______________

Investigation

Investigation Start Date: ______________
Investigator: __________________________________
Date Assigned to Investigation: ______________

Case Status: ☐ Confirmed ☐ Probable ☐ Suspect
Investigation Status: ☐ Open ☐ Closed

Symptom History

Date of Illness Onset: ____________________ **First Symptom:** _______________________

Symptoms: *(Check all that apply)*

☐ Diarrhea ☐ Bloody diarrhea ☐ Constipation ☐ Vomiting ☐ Nausea ☐ Fever (Max)________°F
☐ Fatigue ☐ Chills ☐ Abdominal cramps ☐ Muscle aches ☐ Weight loss ☐ Headache
☐ 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 **Duration of illness:** _____ ☐ Minutes ☐ Hours ☐ Days

***If recovered*, date of recovery:** ______________

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 you stay in an 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

Medication / Health History

To better understand your illness and the factors that may affect illness, we ask a few general questions about medications and health history.

Did you take any antibiotics for this illness?
☐ Yes ☐ No ☐ May Have ☐ Did Not Ask/Answer

***If yes,* what antibiotics did you take?** (i.e. Amoxicillin, Bactrim, Clindamycin, Z-Pak)
____

In the 30 days before your illness began...

Did you take any antibiotics?
☐ Yes ☐ No ☐ May Have ☐ Did Not Ask/Answer

***If yes,* what antibiotics did you take?** (i.e. Amoxicillin, Bactrim, Clindamycin, Z-Pak)
____

Did you have any form of antacid?
☐ Yes ☐ No ☐ May Have ☐ Did Not Ask/Answer

Antacids are medications to block acid, often for heartburn, indigestion or acid reflux.
***If yes,* what medications to block acids did you take?** (i.e. Tums, Pepto, Prilosec)
____

Did you take a probiotic?
☐ Yes ☐ No ☐ May Have ☐ Did Not Ask/Answer

Probiotics are live microorganims (such as certain types of bacteria) that may benefit your health. These can be pills, powders, yogurts, and other fermented dairy products, as well as anything labeled as containing "live and active cultures" or "probiotics."

In the 6 months before your illness began...

Did you have abdominal surgery? (i.e. removal of appendix or surgery of the stomach or large intestine, not including C-section)
☐ Yes ☐ No ☐ May Have ☐ Did Not Ask/Answer

Were you diagnosed or treated for cancer? (including leukemia/lymphoma)
☐ Yes ☐ No ☐ May Have ☐ Did Not Ask/Answer

Are you diabetic? (not including gestational diabetes)
☐ Yes ☐ No ☐ Unknown ☐ Did Not Ask/Answer

Travel History

Did you travel in the 7 days prior to onset of illness? ☐ Yes ☐ No ☐ Unknown

Destination	Date of Arrival	Date of Departure	Notes

In the 6 months before illness, did you travel outside the United States? ☐ Yes ☐ No ☐ May Have ☐ Did Not Ask/Answer
If yes, what countries did you visit? ____

In the 6 months before illness, did any members of your household travel outside the United States?
☐ Yes ☐ No ☐ May Have ☐ Did Not Ask/Answer
If yes, what countries did your household members visit? ____

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

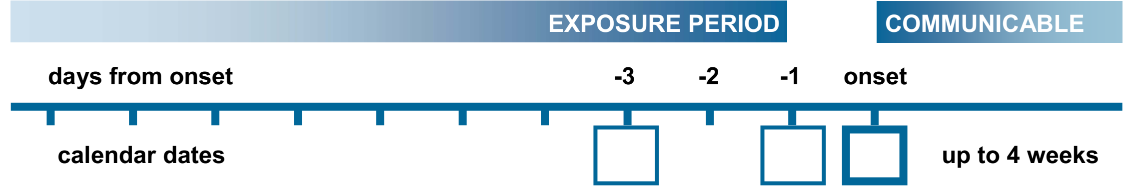
***If yes,* please provide names, onset dates, contact information and any other details for similarly ill persons or related cases:**

Tennessee Department of Health **Shigellosis**	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 generic FoodNet Case Report form.

Last Name: ____________________ **First:** ___________________ **Middle:** ___________ **DOB:** _______________

Infection Timeline

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



Possible Source(s) of Infection During Exposure Period

Yes	No	Unk	
☐	☐	☐	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
☐	☐	☐	Work exposure to human or animal excreta

Provide details (places, dates) about possible sources and risk factors checked above:

Daycare

Attend a daycare center?: ☐ Yes ☐ No ☐ Unknown

Work at a daycare center?: ☐ Yes ☐ No ☐ Unknown

Live with a daycare center attendee?: ☐ Yes ☐ No ☐ Unknown

What type of daycare facility?:
- ☐ Adult day health care
- ☐ Alzheimer's specific day care
- ☐ Child care provided by relative, friend, or neighbor
- ☐ Adult day social care
- ☐ Child care center
- ☐ In-home caregiver

What is the name of the daycare facility?:

Is food prepared at this facility?: ☐ Yes ☐ No ☐ Unknown

Does this facility care for diapered persons?: ☐ Yes ☐ No ☐ Unknown

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 tap water at home?:
- ☐ do not use tap water
- ☐ municipal, city or county
- ☐ private well
- ☐ other ____________________
- ☐ unknown

***If private well*, how was the well water treated?:** ____________________

What is the source of tap water at school/ work?:
- ☐ do not use tap water
- ☐ municipal, city or county
- ☐ private well
- ☐ other ____________________
- ☐ unknown

***If private well*, how was the well water treated?:** ____________________

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

Recreational Water Exposure

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

What was the recreational water type?: ◻ hot spring ◻ hot tub—whirlpool—jacuzzi—spa ◻ interactive fountain ◻ lake—pond—river—stream ◻ ocean ◻ recreational water park ◻ swimming pool (__________) ◻ other (___________) ◻ unknown

Name or location of water exposure:____

Summary of Follow-Up

- ◻ **Exclude from sensitive occupations (HCW, food, daycare) or situations until 2 negative stools**
- ◻ **Culture close contacts in sensitive occupations (HCW, food, daycare) or situations (daycare) regardless of symptom**
- ◻ **Initiate traceback investigation**
- ◻ **Hygiene education provided**
- ◻ **Restaurant inspection**
- ◻ **Daycare inspection**
- ◻ **Investigation of raw milk/dairy**
- ◻ **Other** ____

Alternate Contact Information

Last Name: ______________________ **First:** _____________________ **Relationship:** ◻ Parent ◻ Spouse ◻ Household Member ◻ Friend ◻ Other (_________________________)

Phone Number: ___________________________

Comments