

Listeriosis

Agency: _____

Investigator: _____

Phone number: _____

FOR STATE USE ONLY

Status: Confirmed Probable
 Suspect Not a case

Reviewer initials: _____

Referred to another state: _____

CASE

Last name: _____
First and middle name: _____

Date of Birth: ____ / ____ / ____ Estimated? Age: _____

Gender: Female Male Other _____

Maiden name: _____ Suffix: _____

Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____

Address line: _____

Marital status: Single Married Separated
 Divorced Parent with partner Widowed

Zip: _____ City: _____

Race: American Indian or Alaskan Native Unknown
 Black or African American White
 Hawaiian or Pacific Islander Asian

State: _____ County: _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

Phone: (____) - ____ - ____ Type: _____

Long-term care resident: Yes No Unknown

Parent/Guardian name: _____

Facility name: _____

Parent/Guardian phone: (____) - ____ - ____ Type: _____

EVENT

Diagnosis date: ____ / ____ / ____ Onset date: ____ / ____ / ____

Last name: _____

Event outcome: Survived this illness Died from this illness

First name: _____

Died unrelated to this illness Unknown

Date of Death ____ / ____ / ____

Event exception: Case could not be found
 Case could not be interviewed
 Case refused interview
 Other – see notes Paper only

Outbreak related: Yes No Unknown

Provider title: ARNP MD DO NP PA

Outbreak name: _____

Facility name: _____

Exposure setting: _____

Address line 1: _____

Epi-linked: Yes No Unk To whom: _____

Address line 2: _____

Location acquired: In USA, in reporting state
 In USA, outside reporting state
 Outside USA
 Unknown

Zip code: _____ City: _____

State: _____ County: _____

State: _____ Country: _____

Phone : (____) - ____ - ____ Type: _____

Healthcare provider information

LABORATORY FINDINGS

Laboratory: _____

Accession #: _____

Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____

Specimen source: _____

Result date: ____ / ____ / ____

Result type: Preliminary Final

Test type: _____

Result: Negative
 Positive
 Other _____

Organism: **Listeria**

Type (e.g. serotype): **monocytogenes**

Laboratory: _____

Accession #: _____

Collection date: ____ / ____ / ____

Date received: ____ / ____ / ____

Specimen source: _____

Result date: ____ / ____ / ____

Result type: Preliminary Final

Test type: _____

Result: Negative
 Positive
 Other _____

Organism: **Listeria**

Type (e.g. serotype): **monocytogenes**

Laboratory: _____ Accession #: _____ Collection date: ____/____/____

Date received: ____/____/____ Specimen source: _____ Result date: ____/____/____

Result type: Preliminary Final Test type: _____ Result: Negative
 Positive
 Other _____

Organism: **Listeria** Type (e.g. serotype): **monocytogenes**

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____

Work in a health care setting Yes No Unknown Facility name: _____

Date worked from: ____/____/____ Address: _____

Date worked to: _____ Zip code: _____

Removed from address: Yes No Unknown City: _____ State: _____ County: _____

Phone: (____) - ____ - ____ Type: _____

Removed from _____

Handle food Yes No Unknown Work in a health care setting Yes No Unknown

Are you a provider of care? Yes No Unknown Direct patient care address in Yes No Unknown

Are you a spouse? Yes No Unknown Indirect patient care address in Yes No Unknown

Work in retail setting Yes No Unknown Health care work setting Yes No Unknown

Occupation type: _____ Job title: _____

Work in a health care setting Yes No Unknown Facility name: _____

Date worked from: ____/____/____ Address: _____

Date worked to: _____ Zip code: _____

Removed from address: Yes No Unknown City: _____ State: _____ County: _____

Phone: (____) - ____ - ____ Type: _____

Removed from _____

Handle food Yes No Unknown Work in a health care setting Yes No Unknown

Are you a provider of care? Yes No Unknown Direct patient care address in Yes No Unknown

Are you a spouse? Yes No Unknown Indirect patient care address in Yes No Unknown

Work in retail setting Yes No Unknown Health care work setting Yes No Unknown

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____ Isolated at entry? Yes No Unknown Isolation upon reentry? Yes No Unknown

Admission date: ____/____/____ Discharge date: ____/____/____ Days hospitalized: _____

Currently isolated: Yes No Unk Current isolation type: _____

CLINICAL INFO & DIAGNOSIS

Symptoms: Coma Endocarditis Headache Septicemia
 Encephalitis Fever Nausea Vomiting

Abscesses or lesions present: Yes No Unknown

Diagnosed while pregnant: Yes No Unknown

While pregnant, tested for listeriosis: Yes No Unk

Pregnancy outcome: 1st trimester Live birth
 2nd trimester Miscarriage
 3rd trimester Stillbirth
 Abortion

Test positive: Yes No Unk

Outcome date: ____/____/____

Result date: ____/____/____

Infant less than 4 weeks of age at onset: Yes No Unknown

OTHER LAB FINDINGS

PFGE Pattern (stool specimen from case)

Was PFGE performed: Yes No Unk

IA-Xbal Pattern: _____ IA-BlnI Pattern: _____ CDC-Xbal Pattern: _____ CDC-BlnI Pattern: _____

Environmental specimen testing

Food, medication or environmental samples tested? Yes No Unk

Describe samples: _____

What were the samples tested for? E. coli or EHEC Salmonella Campylobacter
 Listeria Shigella Other testing (specify) : _____

List positive samples: _____ Laboratory: _____

IA-Xbal pattern: _____ IA-BlnI pattern: _____

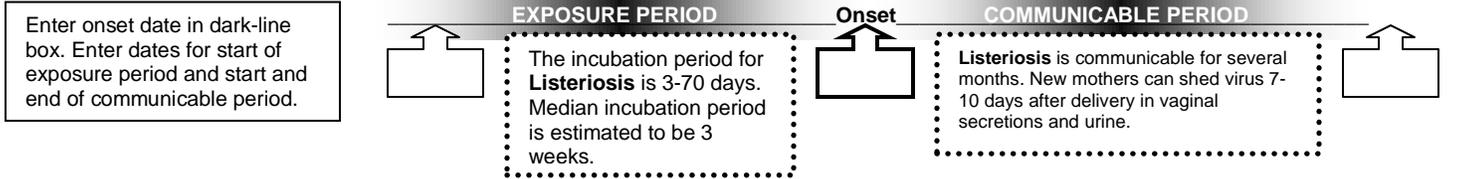
PFGE performed? Yes No Unk CDC-Xbal pattern: _____ CDC-BlnI pattern: _____

TREATMENT

Antibiotics prescribed? Yes No Unknown

Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____	Antibiotic: _____ Date started: ____/____/____ Dose: _____ Unit: <input type="checkbox"/> mg <input type="checkbox"/> ml <input type="checkbox"/> IU # of days: _____ # of times a day: _____ Route: _____
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INFECTION TIMELINE



RISK FACTORS/TRAVEL

In the 3 weeks before the onset of symptoms did the case purchase food products:

Store name	Address	City/State/Zip	County	Date purchased
				/ /
				/ /
				/ /

Dietary Information – In the 3 weeks prior to onset of symptoms did the case consume the following:

Unpasteurized products

Unpasteurized milk: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____/____/____	To dates consumed: ____/____/____
List all source/types: _____	List all brand names: _____	
Unpasteurized cheese: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____/____/____	To dates consumed: ____/____/____
List all source/types: _____	List all brand names: _____	
Other unpasteurized products: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____/____/____	To dates consumed: ____/____/____
List all source/types: _____	List all brand names: _____	

Meat and poultry products

Deli/luncheon meats: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____/____/____	To dates consumed: ____/____/____
List all source/types: _____	List all brand names: _____	
Raw hot dog: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____/____/____	To dates consumed: ____/____/____

List all source/types: _____	List all brand names: _____
Pre-cooked/smoked seafood: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	From dates consumed: ____ / ____ / ____ To dates consumed: ____ / ____ / ____
List all source/types: _____	List all brand names: _____

CONTACTS

Are there symptomatic contacts of the case with same exposures: Yes No Unknown

Name	DOB	Gender	Address/Phone
_____	____ / ____ / ____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: - - -
Relationship to case	List symptoms	Symptom onset date	Is contact a case?
<input type="checkbox"/> Spouse <input type="checkbox"/> Sexual contact <input type="checkbox"/> Child <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Sibling <input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Roommate <input type="checkbox"/> Contact- work/school/etc <input type="checkbox"/> Parent/ guardian <input type="checkbox"/> Unknown/Other	_____	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If this contact is a case create a new event and/or case for this contact.</i> ←			

Name	DOB	Gender	Address/Phone
_____	____ / ____ / ____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____ Zip code: _____ Phone: - - -
Relationship to case	List symptoms	Symptom onset date	Is contact a case?
<input type="checkbox"/> Spouse <input type="checkbox"/> Sexual contact <input type="checkbox"/> Child <input type="checkbox"/> Family member (non-household) <input type="checkbox"/> Sibling <input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Roommate <input type="checkbox"/> Contact- work/school/etc <input type="checkbox"/> Parent/ guardian <input type="checkbox"/> Unknown/Other	_____	____ / ____ / ____	<input type="checkbox"/> Yes <input type="checkbox"/> No
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NOTES:
