

Salmonella

(non-typhi/paratyphi serotypes)

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: _____

Maiden name: _____ Suffix: _____

Gender: Female Male Other _____
Pregnant: Yes No Unk Est. delivery date: ____ / ____ / ____

Address line: _____

Marital status: Single Married Divorced Parent with partner Separated 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
 Died unrelated to this illness Unknown

First name: _____

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: _____ Country: _____

State: _____ County: _____

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

Healthcare provider information

LABORATORY FINDINGS

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: Salmonella	Serotype: _____	

Laboratory: _____	Accession #: _____	Collection date: ____ / ____ / ____
Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: Salmonella	Serotype: _____	

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Date received: ____ / ____ / ____	Specimen source: _____	Test type: _____
Result type: <input type="checkbox"/> Preliminary <input type="checkbox"/> Final	Result date: ____ / ____ / ____	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Organism: Salmonella	Serotype: _____	

OCCUPATIONS

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

Occupation type: _____	Job title: _____
Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

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Worked after symptom onset: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Facility name: _____
Date worked from: ____ / ____ / ____	Address: _____
Date worked to: ____ / ____ / ____	Zip code: _____
Removed from duties: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	City: _____ State: _____ County: _____
Date removed: ____ / ____ / ____	Phone: (____) - ____ - ____ Type: _____
Handle food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Work in a health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend or provide child care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Direct patient care duties in lab or health care setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Attend school: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Health care worker type: _____
Work in a lab setting: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

HOSPITALIZATIONS

Was the case hospitalized? Yes No Unknown

Hospital: _____	Admission date: ____ / ____ / ____	Discharge date: ____ / ____ / ____
Days hospitalized: _____	Isolation type (entry): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Current isolation type: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

CLINICAL INFO & DIAGNOSIS

HUS Diagnosis Yes No Unk Onset Date ____ / ____ / ____

TTP Diagnosis Yes No Unk Onset Date ____ / ____ / ____

Symptoms	Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ____ Days/Hours	Visible bloody diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ____ Days/Hours
	Nausea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ____ Days/Hours	Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ____ Days/Hours
	Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ____ Days/Hours	Abdominal cramps <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ____ Days/Hours
	Headache <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ____ Days/Hours	Chills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ____ Days/Hours
	Muscle weakness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk ____ Days/Hours	
First symptom: _____	Most severe symptom: _____	Date returned to normal activities: ____ / ____ / ____

OTHER LAB FINDINGS

Clinical specimen from case
Was PFGE performed: Yes No Unk

IA-Xbal Pattern	IA-BlnI Pattern	CDC-Xbal Pattern	CDC-BlnI Pattern
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Environmental specimen testing

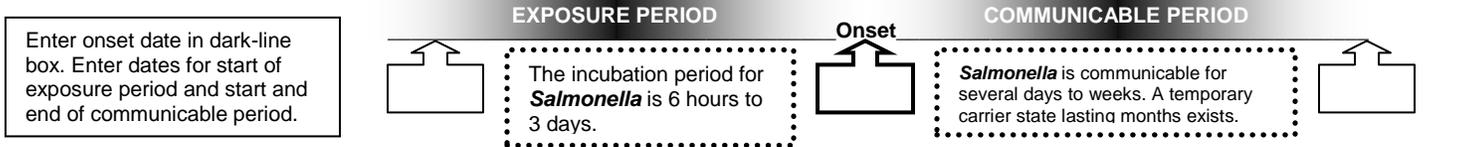
Food, Medication, or environmental samples tested? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Describe samples: (circle positives)	
For what were the samples tested? <input type="checkbox"/> E. coli or EHEC <input type="checkbox"/> Salmonella <input type="checkbox"/> Shigella <input type="checkbox"/> Other testing (specify): _____			
Laboratory: _____		Positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	PFGE performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
IA-Xbal Pattern	IA-BlnI Pattern	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

Risk Factors/Travel Information – In the 3 days prior to onset of symptoms did the case:

Travel	Travel within Iowa? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	City in Iowa: _____	Departure date: ____/____/____	Return date: ____/____/____
	Travel within U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	State: _____	City: _____	Departure date: ____/____/____
	Travel outside U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Country: _____	Departure date: ____/____/____	Return date: ____/____/____

Visit restaurants? Yes No Unknown

If Yes, complete the table below:

County and address are missing from this table

Establishment name	Address/Zip	Date visited	Foods consumed	Others ill?
_____	_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Attend Group Gatherings (e.g. weddings, parties)? Yes No Unknown

If Yes, complete the following table:

Location name	Address/Zip	Date visited	Foods consumed	Others ill?
_____	_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	____/____/____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Where did the case purchase groceries in the 2 weeks before the onset of symptoms:

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

Have other animal contact in home: Yes No Unknown Animal: _____ Animal sick: Yes No Unk

Visit a petting zoo: Yes No Unknown Touched animals: Yes No Unk Animal: _____

Zoo name: _____ Address/Zip/County: _____

Water Exposures – In the 3 days prior to the onset of symptoms did the case

Go swimming? Yes No Unknown

If Yes, complete the table below:

Water Type	Location Type	Dates visited	Facility name / Street address & Zip
<input type="checkbox"/> Hot tub/spa <input type="checkbox"/> Kiddie pool <input type="checkbox"/> River/stream <input type="checkbox"/> Lake	<input type="checkbox"/> Pond <input type="checkbox"/> Water park <input type="checkbox"/> Swimming pool <input type="checkbox"/> Water fountain/ splash pad <input type="checkbox"/> Other	From _____ / ____ / ____ To _____ / ____ / ____	_____
	<input type="checkbox"/> Hotel/motel <input type="checkbox"/> Indoor private <input type="checkbox"/> Indoor public <input type="checkbox"/> Outdoor private <input type="checkbox"/> Outdoor public		

Drinking water supply

Home: <input type="checkbox"/> Bottled <input type="checkbox"/> Commercial Delivery	<input type="checkbox"/> Municipal <input type="checkbox"/> Rural water	<input type="checkbox"/> Well	School: <input type="checkbox"/> Bottled <input type="checkbox"/> Commercial Delivery	<input type="checkbox"/> Municipal <input type="checkbox"/> Rural water	<input type="checkbox"/> Well
Work: <input type="checkbox"/> Bottled <input type="checkbox"/> Commercial Delivery	<input type="checkbox"/> Municipal <input type="checkbox"/> Rural water	<input type="checkbox"/> Well	Child care: <input type="checkbox"/> Bottled <input type="checkbox"/> Commercial Delivery	<input type="checkbox"/> Municipal <input type="checkbox"/> Rural water	<input type="checkbox"/> Well

Other Exposures – In the 3 days prior to the onset of symptoms did the case:

Wear diapers Yes No Unk Have contact with diapers: Yes No Unk

Have contact with immunocompromised person: Yes No Unk Setting: Home Work Other _____

Have sex with someone with similar symptoms: Yes No Unk Sexual preference: Hetero Homo Bisexual Unknown

CONTACTS

Number of people living in case's household: _____

Are there close contacts of the case with same symptoms: Yes No Unknown

Close contacts of the case with the same symptoms

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

If this contact is a case create a new event and/or case for this contact. ←

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

If this contact is a case create a new event and/or case for this contact. ←

NOTES:
