Typhoid Fever

SOURCES OF REPORT (check all that apply)

- Lab
- Infection Control Practitioner
- Physician

**CASE IDENTIFICATION**

**DEMOGRAPHICS**

- SEX
  - female
  - male

- RACE
  - White
  - American Indian
  - Black
  - Asian/Pacific Islander
  - unknown
  - refused to answer
  - other

- DATE OF BIRTH __/__/____
  - or, if unknown, AGE ______

**BASIS OF DIAGNOSIS**

**CLINICAL DATA**

- Symptomatic
  - yes
  - no
  - if yes, ONSET on __/__/____
  - Check all that apply:
    - fever ______ ½
    - rash/rose spots
    - headache
    - hospitalized on __/__/____
      - hospital ___________________________
      - released on __/__/____
    - treated for chronic carriage in ____________
      - year
    - died on __/__/____

**LABORATORY DATA**

- Confirmed
  - yes
  - no
  - if yes, four-fold rise in antibody titer
  - Lab ____________
  - serum dates __/__/____
  - __/__/____
  - isolate cultured
  - Lab ____________
  - specimen date __/__/____

- Source of isolate(s):
  - blood __
  - urine __
  - stool __
  - other _____________
  - isolate submitted to PHL

- PHL specimen # ____________
  - serotype ____________

**LOG FOLLOW-UP CULTURES ON BACK**

**EPI-LINKAGE**

During the exposure period, was the patient

- associated with a known outbreak
- a close contact of a confirmed or presumptive case or carrier
  - was source case reported? □ yes □ not yet

  Specify nature of contact:
  - household
  - daycare

  if yes to any question, specify relevant names, dates, places, etc:
  - pos.
  - neg.

Does the case know about anyone else with a similar illness?

- yes
- no
- could not be interviewed

if yes, give names, onset dates, contact information, and other details.
### INFECTION TIMELINE

Enter onset date in heavy box. Count backwards to figure probable exposure periods. Use grey boxes for S. typhi infections.

<table>
<thead>
<tr>
<th>days from onset</th>
<th>corresponding dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>-21</td>
<td></td>
</tr>
<tr>
<td>-10</td>
<td></td>
</tr>
<tr>
<td>-7</td>
<td></td>
</tr>
<tr>
<td>-1</td>
<td></td>
</tr>
<tr>
<td>onset</td>
<td></td>
</tr>
</tbody>
</table>

### MEDICAL RISK FACTORS

1. Antibiotic use in 30 days before onset
2. Gastrectomized/low stomach acid
3. Regularly uses antacids
4. Immunocompromised
5. Gall bladder disease

### POTENTIAL SOURCES

6. Contact with other people with diarrhea
7. Travel outside the U.S. to _____________
8. Contact with recent foreign arrivals
9. Attends or works in daycare center/nursery
10. Other occupational contact with human excreta
11. Eating at restaurants/public gatherings
12. _____________

Provide details about any possible source or risk factor(s).

### POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

If case was already epi-linked, complete only “Medical Risk Factors.”

- no risk factors could be identified
- patient could not be interviewed

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### CONTACT MANAGEMENT AND FOLLOW-UP

<table>
<thead>
<tr>
<th>HOUSEHOLD ROSTER</th>
<th>sick?</th>
<th>education provided?</th>
</tr>
</thead>
<tbody>
<tr>
<td>name</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>age</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sick?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>onset</td>
<td></td>
<td></td>
</tr>
<tr>
<td>education provided?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>comments</td>
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</tr>
</tbody>
</table>

During the communicable period, did the case prepare food for any public or private gatherings? yes no if yes, provide details below.

If the case or household contact is a food handler, HCW with direct patient contact, or works at or attends daycare, provide details about site, job description, dates worked/attended during communicable period (if applicable), supervisor, etc.

If the patient attends daycare or nursery school, Is the patient in diapers? yes no Are other children or staff ill? yes no

### FOLLOW-UP CULTURE RESULTS

### SUMMARY OF FOLLOW-UP; COMMENTS

- Hygiene education provided
- Work or daycare restriction for case
- Work or daycare restriction for household member
- Daycare inspection
- Follow-up of other household member(s)
- Typhoid carrier agreement signed

### ADMINISTRATION

Remember to copy patient’s name to the top of this page.

Case report sent to OHS on ____/____/____

Completed by __________________ Date ____________ Phone ______________ Investigation sent to OHS on ____/____/____