

Salmonellosis

(non-typhoidal)

ORPHEUS ID

- confirmed
- presumptive
- suspect
- no case

Name _____ County _____
Address _____ Special housing _____

Phone number _____ / _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

ALTERNATIVE CONTACT

Name _____ Phone(s) _____

DEMOGRAPHICS

DOB ____/____/____
if DOB unknown, AGE ____
Sex female male
Language _____
Country of birth _____
Worksites/school/day care center _____
Occupation/grade _____

RACE (check all that apply)
 White
 Black
 Asian
 Pacific Islander
 American Indian/
Alaska Native
 unknown
 other _____
HISPANIC
 Yes No
 unknown declined

PROVIDERS, FACILITIES AND LABS

Reporter Type (circle one)

name and phone number
PMD Lab-fax
MDx Lab-phone
ER Lab-other
ICP HCP
Lab-ELR
Reporter Type (circle one)

name and phone number
PMD Lab-fax
MDx Lab-phone
ER Lab-other
ICP HCP
Lab-ELR
 Ok to contact patient
Local epi_name _____
Date report received by LHD ____/____/____
LHD completion date ____/____/____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic yes no unk
first symptoms ____/____/____
first vomit/diarrhea ____/____/____
Time: _____ am/pm
Check all that apply:
diarrhea yes no unk
bloody diarrhea yes no unk
vomiting yes no unk
fever yes no unk

Deceased yes no date ____/____/____
Cause: _____
Hospitalized: yes: no unk ICU
Name _____
Chart number _____
admit ____/____/____ discharge ____/____/____
Status: Check one:
 alive dead unk transfer
Hospitalized: yes: no unk ICU
Name _____
Chart number _____
admit ____/____/____ discharge ____/____/____
Status: Check one:
 alive dead unk transfer

LABORATORY DATA

Testing Lab _____
Originating Lab _____
Collection date ____/____/____
Specimen tyoe:
 stool
 blood
 urine
 other _____
Isolate sent to OSPHL
 yes no unk
OSPHL Specimen number _____
Serotype _____

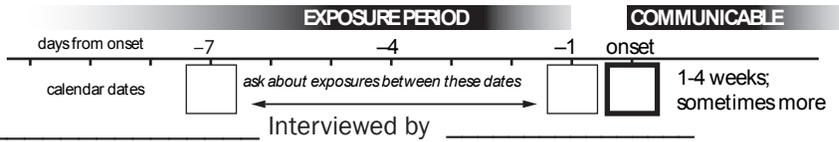
Treatment

Was patient treated with antibiotics or anti-motility drugs for this illness? yes (specify) no unk
Drug name _____ size/dose/frequency _____ start date _____ end date _____



INFECTION TIMELINE

Enter onset date in heavy box. Count back to figure the probable exposure period.



Interviewed yes no Interview date(s) _____

Interviewed by _____

Who patient provider parent other

Reason not interviewed (choose one)

- not indicated unable to reach out of jurisdiction deceased
- refused physician interview medical record review

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Risks Provide ancillary details (names, locations, details) about possible sources and risk factors..

- | yes | no | ref | unk | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIGH RISK FOODS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any chicken anywhere* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IF YES, eat any ground chicken* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any turkey anywhere* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IF YES, eat any ground turkey* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Raw poultry handling at home |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any beef anywhere |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | IF YES, eat any ground beef* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any eggs anywhere |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat raw, runny or lightly cooked eggs |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drink raw or unpasteurized milk* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any soft cheese* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any raw milk (unpasteurized) soft cheese |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Consumer other raw dairy products* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any soft cheese* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any raw milk (unpasteurized) soft cheese |

- | yes | no | ref | unk | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIGH RISK FOODS |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any sprouts (alfalfa, bean, clover)* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any tomatoes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any fresh herbs (basil, cilantro, parsley) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any fresh berries |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any venison or other game meat* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any dried meat (salami, jerky) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any fish or fish product |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat seafood other than fish (e.g., crab, shrimp, oyster) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drink raw or unpasteurized juice or cider* |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eat any food at restaurants |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Food at other gatherings (e.g., potlucks, events) |

* Ask about leftovers, including packaging or containers in trash.
 ** Collect these leftovers for testing. Contact ACDP epi for details.
 There are no leftovers or packaging that can be tested.

EPI-LINKAGE

Associated with a known outbreak? yes no unk

Close contact of another case yes no unk

Specify nature of contact

- co-worker daycare friend
- household sexual

Has the above case been reported? yes no unk

If yes to any question, specify names, dates, places.

Outbreak ID _____

TRAVEL

Y N outside the US to _____

outside Oregon to _____

within Oregon to _____

Provide details about all travel, see Orpheus

departure ___/___/___ return ___/___/___

OTHER POTENTIAL SOURCES

- | yes | no | ref | unk | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Contact with reptiles or amphibians |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Contact with baby chicks |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Contact with other pet animals |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Handle any pet treats (e.g., dog chews) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Contact w/ livestock (cattle, pigs, sheep, goats) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Animal exhibits (petting zoos, fairs, 4H, etc) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Contact with diapered adults or children |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Work exposure to human or animal excreta |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Exposure to kids in child care settings |

WATER

- | yes | no | ref | unk | |
|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Reside in area with home septic system |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drink water from private well |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drink any water directly from a natural spring, lake, pond, stream, or river |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swim or wade in water from a natural setting (e.g., lake, river, pond, ocean) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swim or wade in chlorinated water (e.g., pool, hot tub, water park, fountain) |

OTHER FOLLOW-UP. Provide details as appropriate.

- | yes | no | ref | unk | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | does the case know anyone with a similar illnesses |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | household member is healthcare worker |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | prepared food for public/private gatherings |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | does case work or attend daycare |

- | yes | no | ref | unk | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | does case work or attend daycare |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | work or daycare restriction |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | restaurant inspections |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | case educated about disease transmission |

CASE'S NAME

[Empty box for Case Name]

CASE-CONTACT MANAGEMENT AND FOLLOW-UP

HOUSEHOLD ROSTER (attach additional sheets as needed)

Name	DOB/Age	Sex	Relation to case	Occupation	Education provided	Last exposure	Onset date	Interview date	Sick
_____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> household <input type="checkbox"/> friend <input type="checkbox"/> sexual <input type="checkbox"/> coworker	_____	_____	___/___/___	___/___/___	___/___/___	<input type="checkbox"/> Y <input type="checkbox"/> N
Name	DOB/Age	Sex	Relation to case	Occupation	Education provided	Last exposure	Onset date	Interview date	Sick
_____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> household <input type="checkbox"/> friend <input type="checkbox"/> sexual <input type="checkbox"/> coworker	_____	_____	___/___/___	___/___/___	___/___/___	<input type="checkbox"/> Y <input type="checkbox"/> N
Name	DOB/Age	Sex	Relation to case	Occupation	Education provided	Last exposure	Onset date	Interview date	Sick
_____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> daycare <input type="checkbox"/> household <input type="checkbox"/> friend <input type="checkbox"/> sexual <input type="checkbox"/> coworker	_____	_____	___/___/___	___/___/___	___/___/___	<input type="checkbox"/> Y <input type="checkbox"/> N

ADMINISTRATION

FEBRUARY 2016

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

Case report sent to OHA on ___/___/___

Completed by _____ Date _____ Phone _____ Investigation sent to OHA on ___/___/___