Typhoid and Paratyphoid Fever Investigation Form

☐ Typhoid Fever (Create ALNBS Typhoid Fever Investigation) ☐ Paratyphoid Fever (Create ALNBS Salmonellosis Investigation)

BASIC DEMOGRAPHIC DATA

Last Name:_____ First Name:_____ Middle Name:_____

DOB: __ __ / __ __ /__ __ __ __ Age: _____ ☐years ☐months Current Sex: ☐Female ☐Male ☐Unknown

Is the patient deceased? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

Street Address 1:_____ Street Address 2:_____

City:_____ State:_____ Zip Code:_____ County:_____

Home Phone: (__ __ __) - __ __ __ - __ __ __ __ Cell Phone: (__ __ __) - __ __ __ - __ __ __ __ Work Phone: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

Race: ☐American Indian/Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Unknown

INVESTIGATION SUMMARY

Investigation Start Date: __ __ / __ __ /__ __ __ __ Investigation Status: ☐Open ☐Closed Investigator:_____

REPORTING SOURCE

Date of Report: __ __ / __ __ /__ __ __ __ Reporting Source:_____

CLINICAL

Physician's Name:_____ Phone Number: (__ __ __) - __ __ __ - __ __ __ __ Ext. _____

Was patient hospitalized for this illness? ☐No ☐Unknown ☐Yes If yes: Hospital Name:_____

Admission Date: __ __ / __ __ /__ __ __ __ Discharge Date: __ __ / __ __ /__ __ __ __ Duration of Stay _____ day(s)

Diagnosis Date: __ __ / __ __ /__ __ __ __ Illness Onset Date: __ __ / __ __ /__ __ __ __ Illness End Date: __ __ / __ __ /__ __ __ __

Age at Onset: _____ ☐days ☐hours ☐minutes ☐months ☐unknown ☐weeks ☐years

Did the patient die from this illness? ☐No ☐Unknown ☐Yes Date of Death: __ __ / __ __ /__ __ __ __

EPIDEMIOLOGIC

Is this patient associated with a day care facility? ☐No ☐Unknown ☐Yes Is this patient a food handler? ☐No ☐Unknown ☐Yes

Is this case part of an outbreak? ☐No ☐Unknown ☐Yes If yes, outbreak name:_____

Where was the disease acquired? ☐Indigenous within jurisdiction ☐Out of Country ☐Out of jurisdiction, from another jurisdiction ☐Out of State ☐Unknown

If the answer is out of country, jurisdiction, or state, where was the disease acquired?

Country: _____ State: _____ City: _____ County: _____

Case Status: ☐Confirmed ☐Not a Case ☐Probable ☐Suspect ☐Unknown MMWR Week: _____ MMWR Year:_____

ADMINISTRATIVE

General Comments: _____

_____

PHA4 SUPERVISOR REVIEW

Date Due: __ __ / __ __ /__ __ __ __ Investigation ready for supervisor review: ☐Reviewed (Complete) ☐Reviewed (Incomplete)

Date investigation ready for supervisor review: __ __ / __ __ /__ __ __ __ ☐Reviewed (Not a case) ☐Yes

Review comments (completed by supervisor):_____

CLINICAL EVIDENCE

Fever: ☐No ☐Unknown ☐Yes Relative Bradycardia: ☐No ☐Unknown ☐Yes

Diarrhea: ☐No ☐Unknown ☐Yes Abdominal Pain: ☐No ☐Unknown ☐Yes

Constipation: ☐No ☐Unknown ☐Yes

Anorexia: ☐No ☐Unknown ☐Yes

EXPOSURES

If not a U.S. Citizen, country of origin: _____

If Antibiotic sensitivity testing was performed, was isolate resistant to: ☐Ampicillin ☐Trimethoprim-sulfamethoxazole ☐Chloramphenicol ☐Fluoroquinolones (e.g., Ciprofloxacine)

If patient received Typhoid vaccination, was it administered within **5 years** before illness onset? ☐No ☐Unknown ☐Yes

Typhoid vaccine received: ☐Standard killed ☐Oral Ty21a or Vivotif (Berna) 4 pill series ☐ViCPS or Typhim Vi shot (Pasteur Merieux)

DAY CARE

Attend a day care center? ☐No ☐Unknown ☐Yes Work at a day care center? ☐No ☐Unknown ☐Yes

Live with a day care center attendee? ☐No ☐Unknown ☐Yes What is the name of the day care facility? _____

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

Is food prepared at this facility? ☐No ☐Unknown ☐Yes Does this facility care for diapered persons? ☐No ☐Unknown ☐Yes

FOOD HANDLER

Did the patient work as a food handler after onset of illness? ☐No ☐Unknown ☐Yes

Last date worked as a food handler after onset of illness? __ __ / __ __ /__ __ __ __ Where was the patient a food handler? _____

TRAVEL HISTORY

Did the patient travel outside the U.S. within **30 days** prior to onset of illness? ☐No ☐Unknown ☐Yes

What was the purpose of travel? ☐Business ☐Migration (immigration to US) ☐Other _____ ☐Tourism ☐Visiting relatives/friends

Please specify the destination(s):

Destination 1 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 2 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

Destination 3 Type: ☐Domestic State/Territory: _____ ☐International Country: _____

Mode of Travel: ☐Airplane ☐Bus ☐Car ☐Cruise ship ☐Train Arrival Date: __ __ / __ __ /__ __ __ __ Departure Date: __ __ / __ __ /__ __ __ __

If more than 3 destinations, specify details here: _____

DRINKING WATER EXPOSURE

What is the source of tap water at home? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was home well water treated?
☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

What is the source of tap water at school/work? ☐Do not use tap water ☐Municipal, city, or county ☐Other_____ ☐Private well ☐Unknown

If "Private Well", how was school/work well water treated?
☐Both filtered and disinfected ☐Disinfected ☐Filtered ☐Neither filtered nor disinfected ☐Unknown

Did the patient drink untreated water in the **14 days** prior to onset of illness (e.g., from a river while camping)? ☐No ☐Unknown ☐Yes

RECREATIONAL WATER EXPOSURE

Was there recreational water exposure in the **14 days** prior to illness? ☐No ☐Unknown ☐Yes

What was the recreational water exposure type? (select all that apply)

☐Hot Spring ☐Hot Tub-Whirlpool-Jacuzzi-Spa ☐Interactive Fountain ☐Lake-Pond-River-Stream
☐Ocean ☐Other _____ ☐Recreational Water Park ☐Swimming Pool

If "Swimming Pool", please specify swimming pool type:

☐Camp Pool ☐Hospital/Therapy Pool ☐Hotel/Motel/Resort Vacation Pool
☐Kiddie/Wading Pool ☐Municipal/Community Pool ☐Neighborhood/subdivision/Apartment/Condo Pool
☐Other, specify_____ ☐Private Club/Membership Pool ☐Private Home Pool, not a kiddie/wading pool
☐School/College/University Pool ☐Unknown

Name or location of water exposure: _____

SEAFOOD EXPOSURE

Has the patient eaten seafood in the last **14 days**? ☐No ☐Unknown ☐Yes

Date raw seafood consumed: __ __ / __ __ / __ __ __ __ Time raw seafood consumed: __ __ : __ __ ☐AM ☐PM

RELATED CASES

Does the patient know of any similarly ill persons? ☐No ☐Unknown ☐Yes

If yes, did the health department collect contact information about other similarly ill persons and investigate further: ☐No ☐Unknown ☐Yes

Are the other cases related to this one? ☐No, sporadic ☐Unknown ☐Yes, household ☐Yes, not household ☐Yes, outbreak

Note: Please enter Case ID of epi-linked case(s) in the General Comments section of the ALNBS Investigation.

OTHER CLINICAL DATA

Is the patient a U.S. Citizen? ☐No ☐Unknown ☐Yes

Was the patient symptomatic for **Typhoid** or **Paratyphoid Fever**? ☐No ☐Unknown ☐Yes

Was the case traced to a **Typhoid** or **Paratyphoid** carrier? ☐No ☐Unknown ☐Yes, carrier previously known to HD
☐Yes, carrier previously unknown to HD ☐Yes, unsure if carrier previously known to HD

TYPHOID FEVER CASE CLASSIFICATION

Note: Asymptomatic carriage should not be reported as Typhoid Fever.

1	Did the patient have insidious onset of illness characterized by any of the following? ☐Fever ☐Abdominal pain ☐Anorexia ☐Relative bradycardia ☐Constipation ☐Diarrhea	☐No ☐Unknown ☐Yes
2	Was *Salmonella typhi* isolated from any clinical specimen?	☐No ☐Unknown ☐Yes
3	Is the patient epidemiologically linked to a confirmed case during an outbreak?	☐No ☐Unknown ☐Yes

Confirmed: 1 & 2	**Probable: 1 & 3**

PARATYPHOID FEVER CASE CLASSIFICATION

Create a Salmonellosis investigation in ALNBS.

1	Was *Salmonella paratyphi* isolated from any clinical specimen?	☐No ☐Unknown ☐Yes
2	Did the patient have diarrhea, abdominal pain, nausea, and/or vomiting?	☐No ☐Unknown ☐Yes
3	Is the patient epidemiologically linked to a confirmed case?	☐No ☐Unknown ☐Yes
4	Was *Salmonella paratyphi* detected in a clinical specimen using a non-culture based method?	☐No ☐Unknown ☐Yes

Confirmed: 1	**Probable: 2 & 3**	**Suspect: 4**