

Shigellosis Form for Case Follow-up

I. CASE IDENTIFICATION

(fill out contact information for the patient)

For State Use ID # _____ -SG- _____

Name: _____
Last, First

County: _____

Address: _____
Street

Occupation/Grade: _____

City Zip Code

WorkSite/childcare/School: _____
*please include daycare

Home Phone: () _____

Work Phone: () _____

II. CASE DEMOGRAPHICS

(check the appropriate boxes; fill out date of birth and age in years)

Sex: Female

Race: White Multiracial

Ethnicity: Hispanic

Male

Black

American Indian/Alaskan Native

Non-Hispanic

Date of Birth: ___ / ___ / _____

Asian

Hawaiian/Pacific Islander

Unknown

Age: _____ years

Other → Please specify _____

III. CLINICAL DATA (check all appropriate boxes)

Symptomatic: YES NO Unknown

If yes, Date of onset: ___ / ___ / _____

Date of Diarrhea onset: ___ / ___ / _____

Symptoms

Diarrhea: YES NO Unknown

Vomiting: YES NO Unknown

Fever: YES NO Unknown

Nausea: YES NO Unknown

Bloody Stool: YES NO Unknown

Other: YES NO Unknown

Specify: _____

Outcome: Survived Died Unknown

Date of death: ___ / ___ / _____

Date Received First Report: ___ / ___ / _____

Physician Name: _____

Physician Phone: () _____

Hospitalized: YES NO Unknown

(list all hospitals, admit and discharge dates; attach extra page)

Hospital 1: _____

Date of admission: ___ / ___ / _____

Date of Discharge: ___ / ___ / _____

Hospital 2: _____

Date of admission: ___ / ___ / _____

Date of discharge: ___ / ___ / _____

Treatment w/ antibiotics; specify antibiotic and date

IV. LABORATORY INFORMATION (please attach copy of laboratory report if available; list specimen collection date, test performed, specimen tested, laboratory name, Species and Serotype)

Collection Date	Test Name	Specimen source (Stool, etc.)	Laboratory Name	Serotype/Species

V. POSSIBLE SOURCES OF INFECTION – 7 days prior to onset

(circle correct response and provide details to the right)

V. A. Suspect Foods – refer to the 7 days prior to onset

(ask the case if he/she consumed the following in the 7 days prior to onset. ** Attach additional sheets if necessary.)

1. Y N DK Eat in a Restaurant Date: ___ / ___ / ___ Name/Location _____
Date: ___ / ___ / ___ Name/Location _____

V. B. Other Potential Sources – refer 7 days prior to onset

(ask the case if he/she had contact with the following in the 7 days prior to onset. Attach additional sheets if necessary.)

1. Y N DK Attend or work in daycare or school; Specify where _____
- 1b. Y N DK Attend playgroups or other activities with at least one other child not in the same household;
- 1c. Y N DK Does the case have siblings?
Age: _____
- 1d. Y N DK Does the sibling attend daycare or school? Specify where _____
2. Y N DK Contact with diapered children; Details: _____
3. Y N DK Exposure to other human feces; Details: _____
4. Y N DK Swimming / Recreational water exposure (lake, pool, etc.);
If Y check: lake, pond, river, stream
 Water park
 Swimming or wading pool
 Hot tub/spa, whirlpool, Jacuzzi
Location: _____
Date: ___ / ___ / ___
5. Y N DK Travel outside community, including internationally;
Location (country if international): _____
Date Arrived: ___/___/___ Date Left: ___/___/___
Activities: _____
6. Y N DK Attend any gatherings; Describe event and Location:

Date ___ / ___ / ___
7. Y N DK Came in contact with someone with a similar illness;
If Y check: child in daycare
 Child in school
 Household member, not sexual partner
 Household member, sexual partner
 Male sexual partner
 Female sexual partner
Specify Dates _____
Names: _____
8. What is usual source of drinking water? (circle) municipal well bottled other _____
9. Y N DK Drink untreated water from pond, stream, spring, or lake?
10. Other exposure; Specify _____

VI. Additional Case-Specific Information

1. Does case work as food handler, healthcare worker, daycare attendee; Specify _____

VII. Education and Follow up

- Please emphasize hand washing to case / family.
- Please ensure case will be excluded* if occupation involves food handling, direct patient care, or child care.
- Please ensure case can be contacted in the future for additional questions, specimen collection
- Please ensure environmental health follow-up if any daycare, restaurant or other facility implicated

**Food handlers or children in daycare should be restricted from their activities until they have 2 consecutive negative stool specimens at least 24 hours apart off antibiotics*

VIII. REPORT COMPLETED

Case Report Completed by: _____ Phone Number: () _____

Address: _____

Date Report Completed: ____/____/____

Date Sent to State: ____/____/____

* Fax the completed report to the Notifiable Disease Section at 404-657-7517

For State Use:

Date received first report : ____/____/____

Specimen to GPLH: YES NO UNK MM# _____

Is case associated with an outbreak? YES NO UNK If Yes, EFORS # _____

Is case associated with a known case? YES NO UNK