

Typhoid / Paratyphoid Fever Form for Case Follow-up

I. CASE IDENTIFICATION

(fill out contact information for the patient)

For State Use ID # _____ -ST - _____
ID # _____ -SP - _____

Name: _____
Last, First

County: _____

Address: _____
Street

Occupation/Grade: _____

City _____ Zip Code _____

Work/School/Childcare: _____

Home Phone: () _____ Work Phone: () _____ Other: () _____

II. CASE DEMOGRAPHICS

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

Sex: Female Male
Race: White Black Multiracial American Indian/Alaskan Native Other → Please specify _____
Ethnicity: Hispanic Non-Hispanic
Date of Birth: ____ / ____ / ____
Age: ____ years

III. CLINICAL DATA (check all appropriate boxes)

Symptomatic: YES NO Unknown
If yes, Date of onset: ____ / ____ / ____
Date of fever onset: ____ / ____ / ____

Symptoms

Fever: (____°F) YES NO Unknown
Diarrhea: YES NO Unknown
Constipation: YES NO Unknown
Headache: YES NO Unknown
Abd Pain: YES NO Unknown
Rash: YES NO Unknown
Other: YES NO Unknown

Specify: _____

*If the patient has no symptoms, they should be considered a carrier

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: ____ / ____ / ____

Outcome: Survived Died Unknown

Date of death: ____ / ____ / ____

Was the patient treated with antibiotics? YES NO* Unknown *All cases/carriers should be treated

Name of Antibiotic1: _____ Dates taken: ____ / ____ / ____ -- ____ / ____ / ____

Name of Antibiotic2: _____ Dates taken: ____ / ____ / ____ -- ____ / ____ / ____

Was patient ever treated as a chronic carrier in the past? YES NO Unknown
Is patient immunocompromised? YES NO Unknown
Does patient have gastric disease (prior surgery, taking acid blockers)? YES NO Unknown

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

Collection Date	Test Name	Specimen type (stool, blood, etc)	Result (+/-/pres)	Laboratory Name	Confirmed Typhi/Para?	GPHL ID or ref lab

Date Salmonella Typhi / Paratyphi first isolated: ___ / ___ / ___

Was antibiotic testing performed: Yes No Unk If Yes, was it resistant/intermediate or susceptible to: (circle)

Ampicillin	R	I	S	not tested
Trimethoprim-Sulfamethoxazole	R	I	S	not tested
Fluoroquinolones	R	I	S	not tested
Cloramphenicol	R	I	S	not tested
Other: List 1 _____	R	I	S	not tested
2 _____	R	I	S	not tested
3 _____	R	I	S	not tested

V. POSSIBLE SOURCES OF INFECTION – 30 days prior to onset

(circle correct response and provide details to the right)

V. A. Suspect Foods – refer to the 30 days prior to onset

(ask the case if he/she consumed the following in the 30 days prior to onset. Attach additional sheets if necessary.)

- Y N DK Eating shellfish Store Name and Location: _____
Date Eaten: ___ / ___ / ___ Date Purchased: ___ / ___ / ___
- Y N DK Raw fruit or vegetables; Store Location: _____
- Y N DK Raw milk /other unpasteurized dairy products
- Y N DK Eat in a Restaurant Date: ___ / ___ / ___ Name/Location _____
Date: ___ / ___ / ___ Name/Location _____

V. B. Other Potential Sources – refer 30 days prior to onset

(ask the case if he/she had contact with the following in the 30 days prior to onset. Attach additional sheets if necessary.)

- Y N DK Contact with diapered children; Details: _____
- Y N DK Exposure to other human feces; Details: _____
- Y N DK Swimming / Recreational water exposure (lake, pool, etc.); Location: _____
Date: ___ / ___ / ___
- Y N DK Attend Large Gatherings; Describe Location _____
Date ___ / ___ / ___
- Y N DK Came in contact with someone with a similar illness (Specify Name, Dates, Cx status, and results)
Name: _____ Date onset: ___ / ___ / ___ Cx for Salm? Y N Result: + -
Name: _____ Date onset: ___ / ___ / ___ Cx for Salm? Y N Result: + -
Name: _____ Date onset: ___ / ___ / ___ Cx for Salm? Y N Result: + -
Name: _____ Date onset: ___ / ___ / ___ Cx for Salm? Y N Result: + -

***All sick contacts (before or after patient's onset) must be cultured for Salm to ensure they don't have Para/typhoid.**

VI. Additional Case-Specific Information (circle correct response and provide details to the right)

1. Y* N DK Does case work as food handler, healthcare worker, laboratory worker, daycare attendee;
Specify location and dates _____
*Food handlers, Daycare attendees, & DC workers must be excluded until 3 negative stools (>48hrs antibiotics comp; >30d after onset.)
2. What is the citizenship of the case? _____
- 3a. Y N DK Was the case traced to a typhoid carrier? *If yes, we must make sure the carrier is investigated as a new case
- 3b. Y N DK If yes, was the carrier previously known to the health department?
4. Y N DK Is this case a typhoid carrier? *If a carrier, must have 3 – stools each taken 30 days apart, >48hrs antibiotics comp.
5. Y* N DK Do any household / close contacts work as food handlers, healthcare workers, or daycare attendees?
If Yes, specify _____
*all close contacts who are food handlers, daycare attendees, or DC workers need to be cultured to ensure they do not have Para/Typhoid.

- 6a. Y N DK Did case receive typhoid vaccination (primary series or booster) w/in five years before onset of illness?
- 6b. If yes, indicate the type of vaccine rec'd: Standard killed typhoid shot Y N DK Year Rec'd: _____
Oral Ty21a or Vivotif (Bema) four pill series Y N DK Year Rec'd: _____
VICPS or Typhim Vi shot Y N DK Year Rec'd: _____

- 7a. Y N DK Did the patient travel or live outside the United States during the 30 days before the illness began?
- 7b. If yes, please list countries and dates of travel
City/Country1: _____ Date arrived: ____/____/____ Date Departed: ____/____/____
City/Country2: _____ Date arrived: ____/____/____ Date Departed: ____/____/____
City/Country3: _____ Date arrived: ____/____/____ Date Departed: ____/____/____
- 7c. What was the most recent date of entry or return to the United States? : ____ / ____ / ____
- 7d. What was the purpose of the international travel? Business Tourism Visiting relatives or friends
 Immigration to U.S. OTHER; specify _____

- VII. Education and Follow up**
- Please emphasize hand washing to case / family.
 - Please ensure case will not be handling food.
 - Please ensure case will be excluded if occupation involves food handling, direct patient care, or childcare.
 - Please ensure that the case has 3 negative stool cultures to be obtained 1 month after onset of illness and 48 hours after off antibiotics. Dates of neg cx1: ____/____/____ cx2: ____/____/____ cx3: ____/____/____
- *Please fax negative results to DHR if follow-up testing NOT done at GPLH. *Please fax a copy of any letters sent to patient to DHR.

VIII. REPORT COMPLETED

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