Infant Botulism Investigation Form

Texas Department of State Health Services
Emerging and Acute Infectious Disease Branch
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TEXAS Health and Human Services
Texas Department of State Health Services

PERSONAL DATA

Patient name: _____ Birth date: _____/_____/_____ Sex: _____
Race: ____ W=White; B=Black/African American; N=American Indian/Alaska Native; P=Native Hawaiian/Pacific Islander; A=Asian; O=Other; U=Unknown
Ethnicity: ____ H=Hispanic or Latino; N=not Hispanic or Latino; U=Unknown
Patient address: _____ Patient phone: (_____)_____
Hospital name: _____ Hospital phone: (_____)_____
Physician name: _____ Physician phone: (_____)_____
Physician address: _____
Mother's occupation: _____ Father's occupation: _____
What was infant's birth weight? ____ (lb) ____ (oz) ____ (gm)
Was infant premature? ☐ Yes ☐ No ☐ Unknown
If yes, gestational age: _____ weeks Type of delivery: ☐ Vaginal ☐ C-Section

DIETARY HISTORY (BEFORE ONSET OF PRESENT ILLNESS)

PRESENT ILLNESS—INFANT BOTULISM (Defined as onset of constipation or if no constipation when mother says child became ill)

Before onset of present illness:
Was infant ever breast fed? ☐ Yes ☐ No If yes, for how many weeks? _____
Was infant ever formula fed? ☐ Yes ☐ No If yes, formula with iron? ☐ Yes ☐ No
Was infant primarily (more than 50%):
Breast fed? ☐ Yes ☐ No Formula fed? ☐ Yes ☐ No Fed both approximately equally? ☐ Yes ☐ No
Did infant ever eat or taste (before onset of illness):

Food/Liquid	Never	Once or a few times	Many times	Daily or most days	Principal type or brand (please describe)
formula	☐	☐	☐	☐	
cow's milk	☐	☐	☐	☐	
fruit juices	☐	☐	☐	☐	
cereal	☐	☐	☐	☐	
bread	☐	☐	☐	☐	
syrup/water	☐	☐	☐	☐	
honey/water	☐	☐	☐	☐	
sugar/water	☐	☐	☐	☐	
tea/water	☐	☐	☐	☐	
fruits, cooked	☐	☐	☐	☐	
fruits, raw	☐	☐	☐	☐	
vegetables, cooked	☐	☐	☐	☐	
vegetables, raw	☐	☐	☐	☐	
home-canned foods	☐	☐	☐	☐	
baby foods, jars	☐	☐	☐	☐	
other, specify: _____	☐	☐	☐	☐	

Did the infant use a pacifier? ☐ Often ☐ Sometimes ☐ Rarely ☐ No
If Yes, was it ever dipped in: ☐ Syrup ☐ Honey ☐ Other ☐ Nothing

PHYSICAL FINDINGS

SIGNS: (*are typical)	YES	NO	UNK
a) *Loss of facial expression	☐	☐	☐
b) *Ptosis	☐	☐	☐
c) Extraocular muscle palsies	☐	☐	☐
d) Pupils:			
a. *dilated	☐	☐	☐
b. constricted	☐	☐	☐
c. *sluggish reactivity	☐	☐	☐
e) Trouble swallowing	☐	☐	☐
f) *Constipation	☐	☐	☐
g) Diarrhea	☐	☐	☐
h) *Altered cry	☐	☐	☐
i) *Weak sucking	☐	☐	☐
j) *Muscle weakness			
a. poor head control	☐	☐	☐
b. upper extremities	☐	☐	☐
c. lower extremities	☐	☐	☐
d. "floppy"	☐	☐	☐

SIGNS: (cont'd)	YES	NO	UNK
k) Knee deep tendon reflex			
a. absent	☐	☐	☐
b. depressed	☐	☐	☐
l) *Somnolent	☐	☐	☐
m) Irritable	☐	☐	☐
n) Fever	☐	☐	☐
o) Dehydration	☐	☐	☐
p) *Respiratory difficulty	☐	☐	☐
q) Respiratory arrest	☐	☐	☐
r) Pneumonia	☐	☐	☐
s) Other: _____	☐	☐	☐

DIAGNOSTIC TESTS

Laboratory results:

a) Spinal tap performed? ☐ Yes ☐ No

(Normal in botulism, myasthenia gravis; protein may be elevated in Guillain-Barré)

Date	RBC's	WBC's	Protein	Glucose	Other
(Normal range)	(0)	(<10)	(15-45 mg%)	(50-70 mg%)	
____/____/____	_____	_____	_____	_____	_____
____/____/____	_____	_____	_____	_____	_____

b) Tensilon test *[Negative in botulism and Guillain-Barré, positive in myasthenia gravis. After administration of Tensilon (edrophonium chloride) the patient's eye signs (ptosis & extraocular abnormalities) markedly decrease.]*

Date: _____ Result: ☐ Positive ☐ Negative ☐ Equivocal ☐ Not done

c) EMG results (electromyography): *[(Botulism: action potential diminished after a single supramaximal stimulus, facilitation with repetitive stimuli at 20-50/sec) (Myasthenia gravis: similar to botulism) (In Guillain-Barré: slowed nerve conduction, whereas there is normal conduction in botulism)]*

Date	Nerve Stimulated	Stimulated Frequency	Not done	Amplitude (Circle One)	Facilitation
_____	_____	_____	_____	◯ increase / ◯ decrease	☐ Yes ☐ No
_____	_____	_____	_____	◯ increase / ◯ decrease	☐ Yes ☐ No

CURRENT SYMPTOMS

Mother first noted infant was ill on _____ at _____ weeks of age.
(mm/dd/yyyy)

First symptom: _____

Second symptom: _____

The initial visit to a physician was on _____ at _____ weeks of age.
(mm/dd/yyyy)

The infant was hospitalized on _____ at _____ weeks of age.
(mm/dd/yyyy)

Symptoms noted before patient hospitalized:	YES	NO	UNKNOWN
Constipation: _____ (mm/dd/yyyy)	☐	☐	☐
Poor feeding	☐	☐	☐
Altered cry	☐	☐	☐
Irritable	☐	☐	☐
Poor head control	☐	☐	☐
General weakness	☐	☐	☐
Difficulty breathing	☐	☐	☐
Fever	☐	☐	☐
Other: _____	☐	☐	☐

If infant had constipation, how many bowel movements were occurring?

- ☐ Two or more per day
- ☐ One per day
- ☐ One every other day
- ☐ Two to three per week
- ☐ One per week
- ☐ Less than one per week
- ☐ Other

PHYSICIAN/HOSPITAL DATA

_____ _____ _____
Physician Name | Physician Address | Physician Phone

_____ _____ _____
Physician Name | Physician Address | Physician Phone

_____ _____ _____/_____/_____ _____/_____/_____
Hospital Name | Medical Record # | Date Admitted | Date Discharged

_____
Hospital Address

_____ _____ _____/_____/_____ _____/_____/_____
Hospital Name | Medical Record # | Date Admitted | Date Discharged

_____
Hospital Address

TREATMENT

Respiratory assistance needed? ☐ Yes ☐ No ☐ Unknown If yes, number of days: _____
Oxygen only? ☐ Yes ☐ No Tracheostomy? ☐ Yes ☐ No
Intubation? ☐ Yes ☐ No Ventilator? ☐ Yes ☐ No

Infant feeding: feeding tube? ☐ Yes ☐ No ☐ Unknown If yes, number of days: _____

Antibiotics given	Route (circle one)	Dose (gms/day)	Duration (days)	Date started (mm/dd)
_____	Oral / Parenteral	_____	_____	_____
_____	Oral / Parenteral	_____	_____	_____
_____	Oral / Parenteral	_____	_____	_____
_____	Oral / Parenteral	_____	_____	_____

Was antitoxin given? ☐ Yes ☐ No ☐ Unknown If yes, route? ☐ I.V. ☐ I.M. ☐ Both ☐ Unknown
If yes, how many c.c. total (Connaught adult 10cc/vial, Connaught ped. 2cc/vial): _____total cc
Other specific therapeutic medication given: _____

Patient outcome: ☐ Improving ☐ Recovered ☐ Died If patient died: _____/_____/_____
Date of Death

ENVIRONMENTAL HISTORY

Was there any construction, excessive dust, or environmental change around the home from birth of infant until onset of present illness (infant botulism)?
☐ Yes ☐ No ☐ Unknown

If yes, describe:
_____

_____

Was parent(s) involved in gardening or yard work from birth of infant until onset of present illness?
☐ Yes ☐ No ☐ Unknown

If yes, describe:
_____

_____

Did infant remain away from home for more than 1 week prior to onset of present illness?
☐ Yes ☐ No ☐ Unknown

If yes, describe:
_____

_____

SUBMITTER

Reported by: _____ Phone: (_____)_____ Date Reported: ____/____/____

Investigated by: _____ Investigation Start Date: ____/____/____

Agency: _____ Phone: (_____)_____

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