



Infant Botulism Investigation Form
 Texas Department of State Health Services
 Infectious Disease Surveillance and Epidemiology Branch
 Mailcode 1960
 PO Box 149347
 Austin, TX 78714-9347
 (512) 458-7676 (512) 458-7616 fax

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
cow's milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
fruit juices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
cereal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
syrup/water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
honey/water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
sugar/water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
tea/water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
fruits, cooked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
fruits, raw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
vegetables, cooked	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
vegetables, raw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
home-canned foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
baby foods, jars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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	SIGNS: (cont'd)	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"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DIAGNOSTIC TESTS	Laboratory results: a) Spinal tap performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Normal in botulism, myasthenia gravis; protein may be elevated in Guillain-Barré)</i>																							
	<table border="0"> <tr> <td>(Normal range)</td> <td>(0)</td> <td>(<10)</td> <td>(15-45 mg%)</td> <td>(50-70 mg%)</td> <td></td> </tr> <tr> <td>Date</td> <td>RBC's</td> <td>WBC's</td> <td>Protein</td> <td>Glucose</td> <td>Other</td> </tr> <tr> <td>____/____/____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>____/____/____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	(Normal range)	(0)	(<10)	(15-45 mg%)	(50-70 mg%)		Date	RBC's	WBC's	Protein	Glucose	Other	____/____/____	_____	_____	_____	_____	_____	____/____/____	_____	_____	_____	_____
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	b) Tensilon test <i>[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.]</i> Date: _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Not done																							
	c) EMG results (electromyography): <i>[(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)]</i>																							
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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: _____

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<p>Was there any construction, excessive dust, or environmental change around the home from birth of infant until onset of present illness (infant botulism)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, describe:</p> <hr/> <hr/>
	<p>Was parent(s) involved in gardening or yard work from birth of infant until onset of present illness?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, describe:</p> <hr/> <hr/>
	<p>Did infant remain away from home for more than 1 week prior to onset of present illness?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, describe:</p> <hr/> <hr/>
SUBMITTER	<p>Reported by: _____ Phone: (____)_____ Date Reported: ____/____/____</p> <p>Investigated by: _____ Investigation Start Date: ____/____/____</p> <p>Agency: _____ Phone: (____)_____</p>

Stock Number EF59-11344
 Revised date 05/16/2007