



# Campylobacteriosis Investigation Report

Date Case Reported

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

NEDSS Confirmation Date

\_\_\_\_ / \_\_\_\_ / \_\_\_\_

## INVESTIGATION SUMMARY

|                          |   |                |       |
|--------------------------|---|----------------|-------|
| Investigator             | _____   | NBS Patient ID | _____ |
| Date Assigned            | _____   | NBS Case No.   | _____ |
| Investigation Start Date | _____   | Epi-Linked to  | _____ |
| Investigation End Date   | _____   | Outbreak Name  | _____ |
| Final Case Status        | <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> NAC <input type="checkbox"/> LTF |                |       |

## REPORT SOURCE

|                    |       |                |       |
|--------------------|-------|----------------|-------|
| Reporting Facility | _____ |                |       |
| Reporter Name      | _____ | Reporter Phone | _____ |
| HCP Name           | _____ | HCP Phone      | _____ |

## PATIENT INFORMATION

|                      |  |                         |   |
|----------------------|--|-------------------------|---|
| Date of Interview    | ____ / ____ / ____   | Relationship to Patient | _____   |
| Last Name            | _____  | First Name              | _____   |
| DOB                  | _____  | Age                     | _____   |
|                      |  | Gender                  | <input type="checkbox"/> M <input type="checkbox"/> F |
| Street Address       | _____  |                         |   |
|                      |  | City                    | _____   |
| State/ Zip           | _____  |                         |   |
|                      |  | County                  | _____   |
| Phone Number(s)      | _____  |                         |   |
|                      |  | Alternate No.           | _____   |
| Parent/Guardian Name | _____  |                         |   |
| Occupation/Employer  | _____  |                         |   |
| Ethnicity            | <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic                            |                         |   |
| Race                 | <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other _____ |                         |   |
|                      | <input type="checkbox"/> Asian <input type="checkbox"/> Unknown                                    |                         |   |

## SCHOOL/DAYCARE INFORMATION

|   |   |                      |       |
|---|---|----------------------|-------|
| Attend or Work At:                                  | <input type="checkbox"/> School <input type="checkbox"/> Daycare <input type="checkbox"/> N/A |                      |       |
| Name of School                                      | _____   | Name of daycare      | _____ |
| School Contact and Title                            | _____   | Daycare Director     | _____ |
| School Address                                      | _____   |                      |       |
|   |   | Daycare Address      | _____ |
| School Phone Number                                 | _____   | Daycare Phone Number | _____ |
| School/Daycare aware of patient's diagnosis?        | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown     |                      |       |
| Any notification of similar illness been sent home? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown     |                      |       |
| Written notification provided to parent/guardian?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown     |                      |       |

**CLINICAL INFORMATION**

Onset Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Diagnosis Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Illness Duration \_\_\_\_\_ Days

Outcome  Recovered  Ongoing Symptoms  Died

**Signs and Symptoms**

Y N UNK

Diarrhea Maximum # of Stool in 24 hrs. \_\_\_\_\_

Blood Diarrhea

Abdominal Cramps or pain

Nausea

Vomiting

Fever Highest Temp (°F) \_\_\_\_\_

Other \_\_\_\_\_

**Clinical Findings**

Y N UNK

Invasive

Guillain-Barré Syndrome

**Hospitalization**

Y N UNK

Hospitalized overnight for illness

**Underlying Health Conditions**

\_\_\_\_\_  
 \_\_\_\_\_

Hospital Name \_\_\_\_\_

Admission Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Discharge Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Patient Treatment**

Y N UNK

Antibiotics/Medication given

Y N UNK

Died of illness

Autopsy

**Antibiotics/Medications Taken**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Death \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Place of Death \_\_\_\_\_

**Laboratory**

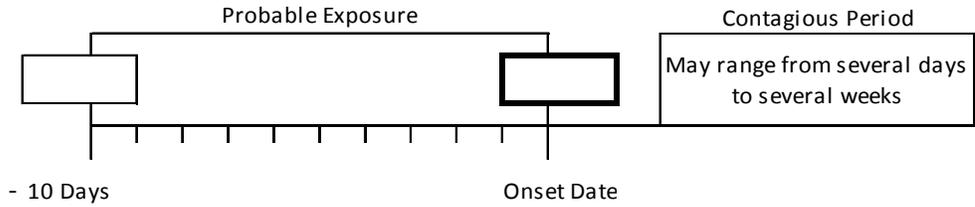
Collection date (earliest suspect date) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Lab Report Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Specimen source  Blood  Stool  Urine  Other \_\_\_\_\_  N/A - No lab testing performed

**Campylobacter species** \_\_\_\_\_

**INFECTION TIMELINE**

Enter onset date (first sx) in outlined box. Count backward to figure probable exposure period.



\*Usually the incubation period is 2 - 5 days, with a range of 1 - 10 days depending on dose ingested

**EXPOSURE (Refer to dates above)**

**Y N UNK**

Travel out of the state or country

Destination/Dates \_\_\_\_\_

Number of Household contacts \_\_\_\_\_ Number ill \_\_\_\_\_

Other non-household members with similar symptoms

If "YES", complete an investigation form for all symptomatic contacts

Contact with diapered or incontinent child or adult

**Infant Case**

Formula Brand/ Type/ Powder or pre-mixed: \_\_\_\_\_

When was the formula purchased? \_\_\_\_\_

What type of water is being used to prepare formula: \_\_\_\_\_

Type and brand of baby bottle being used \_\_\_\_\_

Baby food brand/type \_\_\_\_\_

Infant's feeding is primarily:  Breast Fed  Formula Fed  Both Equally

**Chronic or GI Issues**

**Y N UNK**

**FOOD HISTORY**

Consumed / Handled / Prepared Poultry

If "Yes", was the poultry  Undercooked  Raw  Fully Cooked

Consumed / Handled / Prepared Eggs

If "Yes", were the eggs  Undercooked  Raw  Fully Cooked

Raw fruits or vegetables Types: \_\_\_\_\_

Unpasteurized dairy products or juices Types: \_\_\_\_\_

Group meal (wedding, potluck, reception, etc)

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Location \_\_\_\_\_

Foods Eaten \_\_\_\_\_

Restaurant Name & Location \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Foods Eaten \_\_\_\_\_

Case Name (Last, First): \_\_\_\_\_

| Y                        | N                        | UNK                      | WATER SOURCES   |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Source of drinking water<br><input type="checkbox"/> Individual well <input type="checkbox"/> Shared well <input type="checkbox"/> Public Water system <input type="checkbox"/> Bottle water<br>If well water, was the water : <input type="checkbox"/> Filtered <input type="checkbox"/> Disinfected <input type="checkbox"/> Both |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Drank untreated/unchlorinated water (e.g. surface, well)  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)<br>Location _____  |
| <hr/>                    |                          |                          |   |
| ANIMAL EXPOSURE          |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Case or household member lives or works on farm/dairy   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Work with animals or animal products (list type) _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any contact with pets, animals or livestock<br>Specify animal / Location: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was pet/animal sick?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was the pet/animal recently obtained?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pet food or pet treats _____  |
| <hr/>                    |                          |                          |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Outdoor or recreational activity _____  |

**OPEN ENDED FOOD HISTORY**

Start with the day of illness onset and work backwards.

Day 1 - Date of Onset (\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_)  as reported by the case  foods commonly eaten

|   |   |  |
|---|---|--|
| Breakfast <input type="checkbox"/> At Home <input type="checkbox"/> Out | Lunch <input type="checkbox"/> At Home <input type="checkbox"/> Out | Dinner <input type="checkbox"/> At Home <input type="checkbox"/> Out |
| _____   | _____   | _____  |
| _____   | _____   | _____  |
| _____   | _____   | _____  |

Day 2 - Day Prior to Onset (\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_)  as reported by the case  foods commonly eaten

|   |   |  |
|---|---|--|
| Breakfast <input type="checkbox"/> At Home <input type="checkbox"/> Out | Lunch <input type="checkbox"/> At Home <input type="checkbox"/> Out | Dinner <input type="checkbox"/> At Home <input type="checkbox"/> Out |
| _____   | _____   | _____  |
| _____   | _____   | _____  |
| _____   | _____   | _____  |

Day 3 - (\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_)  as reported by the case  foods commonly eaten

|   |   |  |
|---|---|--|
| Breakfast <input type="checkbox"/> At Home <input type="checkbox"/> Out | Lunch <input type="checkbox"/> At Home <input type="checkbox"/> Out | Dinner <input type="checkbox"/> At Home <input type="checkbox"/> Out |
| _____   | _____   | _____  |
| _____   | _____   | _____  |
| _____   | _____   | _____  |

Case Name (Last, First): \_\_\_\_\_

Day 4 (\_\_\_\_ / \_\_\_\_ / \_\_\_\_)  as reported by the case  foods commonly eaten

Breakfast  At Home  Out      Lunch  At Home  Out      Dinner  At Home  Out

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Day 5 (\_\_\_\_ / \_\_\_\_ / \_\_\_\_)  as reported by the case  foods commonly eaten

Breakfast  At Home  Out      Lunch  At Home  Out      Dinner  At Home  Out

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How was this person likely exposed to the disease: (Check all that apply)

- Food     Drinking water     Recreational water     Person  
 Animal     Environment     Unknown/Indeterminate

Where did exposure probably occur?  In TX (County/City: \_\_\_\_\_)

- U.S. but not in TX (State: \_\_\_\_\_)     Not in U.S. (Country/Region: \_\_\_\_\_)     Unknown  
 No risk factors or exposures identified

| PUBLIC HEALTH CONCERNS   |                          |                          | PUBLIC HEALTH ACTIONS  |  |
|--------------------------|--------------------------|--------------------------|--|--|
| Y                        | N                        | UNK                      |  |  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Employed in food establishment                                 | <input type="checkbox"/> Exclude probable and confirmed cases in sensitive occupations/situations (HCW, food, child care) until asymptomatic |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Non-occupational food handling during contagious period        | <input type="checkbox"/> Hand hygiene education provided   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Employed as health care worker                                 | <input type="checkbox"/> FBI/restaurant information sent to sanitarian   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Employed in child care   | <input type="checkbox"/> Child care facility information provided to licensing as needed if facility is non-compliant                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Attends child care/school                                      | <input type="checkbox"/> Raw milk/dairy information sent to M&D Group  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Symptomatic HH member or close contact in sensitive occupation | <input type="checkbox"/> Child care/ school exclusion criteria provided  |
|                          |                          |                          |  | <input type="checkbox"/> Child care/ school awareness letter provided  |
|                          |                          |                          |  | <input type="checkbox"/> Licensing reporting requirements provided to child care center  |

NOTES:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_