



Salmonellosis (non-typhoidal) 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

(i.e. Extra-Intestinal Infection, bacteremia, sepsis)

Underlying Health Conditions

Hospitalization

Y N UNK

Hospitalized overnight for illness

Hospital Name _____

Admission Date _____ / _____ / _____

Discharge Date _____ / _____ / _____

Patient Treatment

Y N UNK

Antibiotics/Medication given

Antibiotics/Medications Taken

Y N UNK

Died of illness

Autopsy

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

Salmonella species _____

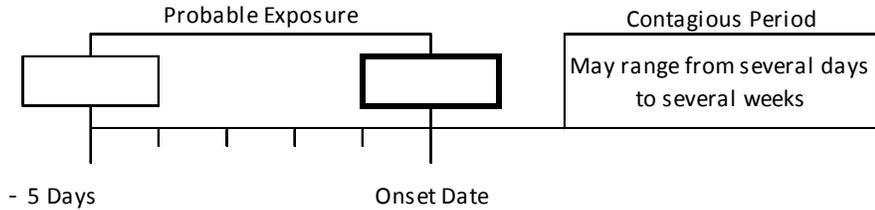
Salmonella serotype _____

PFGE pattern _____

Case Name (Last,First): _____

INFECTION TIMELINE

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



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 <input type="checkbox"/> Individual well <input type="checkbox"/> Shared well <input type="checkbox"/> Public Water system <input type="checkbox"/> Bottle water 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) Location _____

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 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reptile/Amphibian (e.g. lizard, snake, turtle, frogs) Specify animal / Location: _____

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Outdoor or recreational activity _____
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OPEN ENDED FOOD HISTORY

Start with the day of illness onset and work backwards.

Day 1 - Date of Onset (_____/_____/_____) <input type="checkbox"/> as reported by the case <input type="checkbox"/> 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 (_____/_____/_____) <input type="checkbox"/> as reported by the case <input type="checkbox"/> 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 - (_____/_____/_____) <input type="checkbox"/> as reported by the case <input type="checkbox"/> 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:
