



# Shigellosis 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     M     F

Street Address \_\_\_\_\_      City \_\_\_\_\_

State/ Zip \_\_\_\_\_      County \_\_\_\_\_

Phone Number(s) \_\_\_\_\_      Alternate No. \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Occupation/Employer \_\_\_\_\_

Ethnicity     Hispanic     Not Hispanic

Race     White     Black     Other \_\_\_\_\_

Asian     Unknown

## SCHOOL/DAYCARE INFORMATION

Attend or Work At:     School     Daycare     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?     Yes     No     Unknown

Any notification of similar illness been sent home?     Yes     No     Unknown

Written notification provided to parent/guardian?     Yes     No     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

Hemolytic-Uremic 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

Shigella species \_\_\_\_\_



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

Y	N	UNK			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains) Location _____		
<b>ANIMAL EXPOSURE</b>					
<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"/>	Outdoor or recreational activities _____		
<b><i>Shigella Flexneri</i></b>					
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any type of sexual contact during the exposure period Number of male sexual partners _____ Number of female sexual partners _____		
<b>OPEN ENDED FOOD HISTORY</b>					
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 all cases in sensitive occupation/situation (HCW, food, child care) until confirmation of 2 consecutive, negative stool specimens
<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:**

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