

Campylobacteriosis

ALASKA

FOR STATE USE ONLY

#

___/___/___ case report

confirmed

presumptive

___/___/___ interstate

suspect

Although always a good idea, case investigations are required only when there is suspicion of an outbreak or there are an unusual number of cases

Date investigation initiated _____

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City County Zip

_____ e-mail address _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

Lab Infection Control Practitioner

Physician _____

Name _____

Phone _____ Date ___/___/___
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX
 female male

HISPANIC yes no unknown

RACE

White AI/AN

Black Asian/Pacific Islander

unknown refused to answer

other _____

DATE OF BIRTH ___/___/___
m d y

or, if unknown, AGE _____

Worksites/school/day care center _____

Occupations/grade _____

BASIS OF DIAGNOSIS

CLINICAL DATA

Symptomatic: yes no unk

if yes, ONSET on ___/___/___
m d y

Check all that apply:

diarrhea yes no unk

bloody diarrhea yes no unk

Hospitalized: yes no unk

name of hospital _____

date of admission ___/___/___
m d y

date of discharge ___/___/___
m d y

Transferred to/from another hospital:

yes no unk

transfer hospital name _____

Outcome: survived died unk

date of death ___/___/___
m d y

LABORATORY DATA

Culture confirmed: yes no

if yes, Lab _____

Specimen: stool

blood

Specimen collected ___/___/___
m d y

Isolate submitted to PHL?

yes no unk

PHL specimen # _____

Species: *C. jejuni*

other _____

unk

EPI-LINKAGE

During the exposure period, was the patient...

associated with a known outbreak? yes no unk

a close contact of a **confirmed** or **presumptive** case? yes no unk

Has the above case been reported? yes not yet

Specify nature of contact:

household sexual daycare _____

if yes to any question, specify relevant names, dates, places, etc:



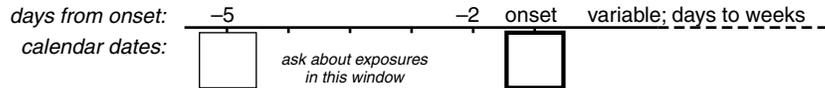
PATIENT'S NAME >

INFECTION TIMELINE

EXPOSURE PERIOD

COMMUNICABLE PERIOD

Enter onset date in heavy box.
Count back to figure the probable exposure period.



POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

Skip this section if case is already epi-linked.

- no risk factors could be identified
- patient could not be interviewed

- | | | | |
|---|--------------------------|--------------------------|--|
| | yes | no | |
| e | <input type="checkbox"/> | <input type="checkbox"/> | other unpasteurized milk products |
| f | <input type="checkbox"/> | <input type="checkbox"/> | food at restaurants (e.g., queso fresco) |
| g | <input type="checkbox"/> | <input type="checkbox"/> | food at gatherings (potlucks, events) |

- | | | | |
|---|--------------------------|--------------------------|--|
| | yes | no | |
| i | <input type="checkbox"/> | <input type="checkbox"/> | livestock, poultry |
| j | <input type="checkbox"/> | <input type="checkbox"/> | persons with diarrheal illness |
| k | <input type="checkbox"/> | <input type="checkbox"/> | diapered children or adults |
| l | <input type="checkbox"/> | <input type="checkbox"/> | occupational exposure to excreta |
| m | <input type="checkbox"/> | <input type="checkbox"/> | travel outside the U.S. to _____ |
| n | <input type="checkbox"/> | <input type="checkbox"/> | recreational water exposure (lakes, rivers, pools, etc.) |

SUSPECT FOODS

- | | | | |
|---|--------------------------|--------------------------|---|
| | yes | no | |
| a | <input type="checkbox"/> | <input type="checkbox"/> | rare/undercooked poultry |
| b | <input type="checkbox"/> | <input type="checkbox"/> | handling/preparation of poultry carcass |
| c | <input type="checkbox"/> | <input type="checkbox"/> | raw/rare meat |
| d | <input type="checkbox"/> | <input type="checkbox"/> | raw/unpasteurized milk |

OTHER POTENTIAL SOURCES

- | | | | |
|---|--------------------------|--------------------------|---|
| | yes | no | |
| h | <input type="checkbox"/> | <input type="checkbox"/> | household pets, especially puppies and kittens |
| o | | | if yes, did pet have diarrhea? <input type="checkbox"/> yes <input type="checkbox"/> no |

Provide details about possible sources and risk factors

CASE-CONTACT MANAGEMENT AND FOLLOW-UP

Case education provided? yes no unknown

HOUSEHOLD ROSTER

name	age	occupation	diarrhea			onset date m/d/y	education provided			comments
			yes	no	unk		yes	no	unk	
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Does the case know about anyone else with a similar illness? yes no could not be interviewed
if yes, give names, onset dates, contact information, and other details.

During the communicable period, did the case prepare food for any public or private gatherings? yes no if yes, provide details below.

If the case or household contact is a food handler, HCW with direct patient contact, or works at or attends daycare, provide details about site, job description, dates worked/attended during communicable period (if applicable), supervisor, etc.

- Does the patient attend daycare or nursery school? yes no
- If yes: Is the patient in diapers? yes no
- Are other children or staff ill? yes no

SUMMARY OF FOLLOW-UP AND COMMENTS. Provide details as appropriate.

- | | |
|---|--|
| <input type="checkbox"/> hygiene education provided | <input type="checkbox"/> restaurant inspection |
| <input type="checkbox"/> work or daycare restriction for case | <input type="checkbox"/> investigation of raw milk dairy |
| <input type="checkbox"/> daycare inspection | <input type="checkbox"/> _____ |
| <input type="checkbox"/> work or daycare restriction for household member | |



ADMINISTRATION

Fax to: (907) 563-7868

Remember to copy patient's name to the top of this page.

Completed by _____ Date _____ Phone _____ Case report sent to SOE on ___/___/___
Investigation sent to SOE on ___/___/___