Botulism Alert Summary

Enterics Officer taking botulism call should fill out information upon 1. initial case review, 2. follow-up call approximately one week later, and 3. final call 4-8 weeks later (when final lab tests known). Botulism surveillance officers will provide back-up as needed. Please request copy of EMG and copy of discharge summary, to file with report.

Alert # _____ **Pt. Name** _____ **Date (1st call)** _____ **State** _____

INDIVIDUAL REPORTING (person initiation call)

Name _____ **Affiliation** _____ **Phone #** _____

Patient Name _____ **Age** _____ **Sex** _____ **Date of Birth** _____

Address _____ **Phone #** _____

Hospital _____

Address _____ **Phone #** _____

Name of Attending Physician _____ **Phone #** _____

Consultants _____ **Phone #** _____

Neurologist (if involved) _____ **Phone #** _____

PRELIMINARY HISTORY

Acute illness in the past month ◯ No ◯ Yes _____

Underlying medical problems ◯ No ◯ Yes _____

Prior gastric surgery or abnormal GI tract ◯ No ◯ Yes _____

Date of presumptive exposure, if known _____ **Date of first symptoms (DOO)** _____

Date first saw MD _____ **Date hospitalized** _____

Admitting diagnosis _____

Date botulism dx first seriously considered _____ **Suspected link to known outbreak** ◯ No ◯ Yes

Date of first contact with State Health Dept. _____ **Date of first contact with CDC** _____

Reason for SHD or CDC contact ◯ lab testing ◯ antitoxin ◯ consultation ◯ other _____

Problems with communication or contact _____

SYMPTOMS

Indicate if present at time of review of case by SHD or CDC. **Date:** _____

Symptoms reported present within first 24 hours:

Yes	No	Unk		Yes	No	Unk	
◯	◯	◯	Abdominal Pain	◯	◯	◯	Dyspnea
◯	◯	◯	Nausea	◯	◯	◯	Fatigue
◯	◯	◯	Diarrhea	◯	◯	◯	Dry Mouth
◯	◯	◯	Blurred Vision	◯	◯	◯	Sore Throat
◯	◯	◯	Diplopia	◯	◯	◯	Urinary Retention
◯	◯	◯	Photophobia	◯	◯	◯	Constipation
◯	◯	◯	Dysphagia	◯	◯	◯	Dizziness
◯	◯	◯	Dysphonia	◯	◯	◯	Paresthesias
◯	◯	◯	Muscle Weakness	◯	◯	◯	Convulsions
◯	◯	◯	Upper Distal	Other			_____
◯	◯	◯	Upper Proximal				_____
◯	◯	◯	Lower Distal				_____
◯	◯	◯	Lower Proximal				

Where did the muscle weakness start

_____

_____

SIGNS

Indicate if present at time of case review. **Date:** _____

Mark if present at first medical exam for this illness. **Date:** _____

Yes	No	Unk		Yes	No	Unk	
○	○	○	Ptosis	○	○	○	Abnormal Sensory
○	○	○	Extraocular Palsy				Specify _____
			Pupils	○	○	○	Ataxia
○	○	○	Dilated	○	○	○	Symmetrical
○	○	○	Constricted	○	○	○	Nystagmus
○	○	○	Mid-position				DTR's
○	○	○	Reactive	○	○	○	Normal
○	○	○	Equal	○	○	○	Hypoactive
○	○	○	Decreased Corneals	○	○	○	Hyperative
○	○	○	Facial Paralysis	○	○	○	Symmetric
○	○	○	Symmetric	○	○	○	Abnl Mental State
○	○	○	Decreased Gag	○	○	○	Fever
○	○	○	Decreased ability to protrude tongue	○	○	○	Respiratory Impairment
○	○	○	Weakness or paralysis or extremity(ies)	○	○	○	Does patient have a wound
○	○	○	Upper				Specify _____
○	○	○	Lower				Date wound sustained _____
○	○	○	Symmetric				How treated _____

Toes ○ Down ○ Up ○ Unk

LABORATORY STUDIES

Spinal tap ○ No ○ Yes

Date	RBC's	WBC's	Cells	Protein	Glucose	Other

Tensilon test Date _____ ○ Positive ○ Negative ○ Not Done

Comments _____

EMG

Date	Area Tested	Muscle Group Weak	Frequency (hertz)	Amplitude (nl)	Facilitation (yes/no)

Vital Capacity Date _____ _____ cc

Date _____ _____ cc

Date _____ _____ cc

Antitoxin given: ○ No ○ Yes **Type** _____ **Route** _____

Amount (#vials) _____ **Date** _____

Amount (#vials) _____ **Date** _____

Sensitivity testing done prior to administration: ○ No ○ Yes **Result** _____

Hypersensitivity reaction: _____ **Ansphylasis** _____

Serum sickness: _____ **Other treatment given** _____

MORBIDITY

NG tub feeding: ☐ Yes ☐ No ☐ Unk Dates _____

Respirator: ☐ Yes ☐ No ☐ Unk Dates _____

Tracheostomy: ☐ Yes ☐ No ☐ Unk Dates _____

Number of days in intensive care: _____

Outcome: ☐ Recovered ☐ Died Cause of death: _____

Number of days in hospital: _____ Date discharged from hospital: _____

Discharged to: ☐ Home ☐ Nursing Home ☐ Rehab facility ☐ Other _____

BOTULISM LABORATORY TESTS

Tested at: ☐ CDC ☐ State Lab _____ ☐ Other _____

Indicate if mouse died by non-neutralizable:

Serum: Date _____ Result .5ml _____ 1ml _____

Date _____ Result .5ml _____ 1ml _____

Date _____ Result .5ml _____ 1ml _____

Gastric: Date _____ Result _____

Stool: Date _____ Result toxin test _____

standard culture _____

enrichment culture _____

Food items (including items tested and results as "+" or "-"):

1. _____ _____
2. _____ _____
3. _____ _____

Vehicle implicated: _____ Date ingested: _____

If botulism, number of cases in outbreak: _____

FINAL DIAGNOSIS

☐ BOTULISM

☐ Adult foodborne ☐ Adult Intestinal Colonization ☐ Wound

☐ Uncharacterized _____

☐ GULLLAN BARRE

☐ STROKE

☐ OTHER Specify: _____

EMG result and discharge summary requested: ☐ No ☐ Yes

Comments: