

Salmonellosis Case Report Form

Version 2.2, March 2012

(Please report *Salmonella* Typhi as typhoid fever, not salmonellosis)

This form is designed to aid in completing the Extended Data screen in Merlin for salmonellosis cases

*Blue fields are REQUIRED

Merlin case #: _____

Date CHD reported to BOE: _____

Date CRF submitted: _____

I. PROFILE DETAIL

SSN: _____

*Last name: _____

First name: _____

Middle: _____

Parent name: _____

*Gender: Male
 Female
 Unk

*Birth date: _____ Death date: _____

*Race: American Indian/Alaska Native
 Asian/Pacific Islander
 Black
 White
 Other
 Unk

*Ethnicity: Hispanic
 Non-Hispanic
 Unk

Address: _____

*Zip: _____ *County: _____

City: _____ *State: _____

Home phone: _____

Other phone: _____

Emer. phone: _____

Profile specific notes:

II. CASE INFORMATION

Investigator: _____

CHD ref #: _____

Animal exposure:

*Imported: Acquired in FL
 Acquired in US, not in FL
 Acquired outside US
 Unk

Origin: _____

*Outbreak: Outbreak-associated
 Sporadic
 Unk

Outbreak ID: _____

*Case classification: Primary
 Secondary
 Unk

*1st notified by ELR: Yes
 No
 Unk

Reporter type: _____

Military base: _____

Reporter's name: _____

III. CLINICAL

*DX status: Confirmed
 Probable
 Suspect
 Unk

Case definitions: http://www.doh.state.fl.us/Disease_ctrl/epi/surv/CaseDefinitions.html

*Investigated: Yes
 No Date investigated: _____

Interviewed: Yes
 No Date interviewed: _____

Symptomatic at interview: Yes
 No
 Unk

Final known outcome: Died
 Ill at time of reporting
 Recovered
 Unk

ED visit: Yes
 No
 Unk

*Inpatient hospitalization: Yes
 No
 Unk Date admitted: _____
Date discharged: _____

Prophylaxed: Yes
 No
 Unk
 N/A

Date onset: _____ Date diagnosis: _____

Lab report date: _____ *CHD notified date: _____

Clinical notes (treatment, etc.)

IV. SENSITIVE EMPLOYMENT/ATTENDANCE INFORMATION

*Day care: No Attendee Staff Unk
*Occupation: No or non-sensitive occupation
 Healthcare worker
 Food handler
 Unk

Company: _____

Address: _____

Zip: _____

City: _____ State: _____

Phone: _____ Fax: _____

Last date attended: _____

V. PROVIDER INFORMATION

Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Case-Finding

Did you ask the patient (or patient's proxy, e.g., guardian/caregiver) to identify contacts who were exposed to the patient or a common point-source?

This would include asymptomatic contacts and household contacts, and would typically be completed during the initial case interview. This does not include information gathered in a mailed questionnaire.

- Yes, and contacts were identified
Date 1st contact was identified: _____
- Yes, but there were no contacts
- Yes, but the patient refused to answer
- No

Isolation

Did you recommend that the patient be excluded from a sensitive situation (e.g., day care attendee or staff, food handler, or health care worker)?

Exclusion can be based on follow-up testing until patient is negative or excluding until asymptomatic. Exclusion would include re-assigning employees in sensitive situations to job duties that are not sensitive.

- Yes
Date patient notified of exclusion recommendation: _____
- No, the patient was in a sensitive situation, but was no longer infectious at the time of interview
- No, the patient was not in a sensitive situation
- No

Education

If the patient was symptomatic at the time of interview, did you provide the patient (or patient's proxy, e.g., guardian/caregiver) with information on preventing disease transmission in order to prevent the patient from infecting others?

This would not include educational materials mailed to the patient.

- Yes
- No

VII. CASE SYMPTOMS

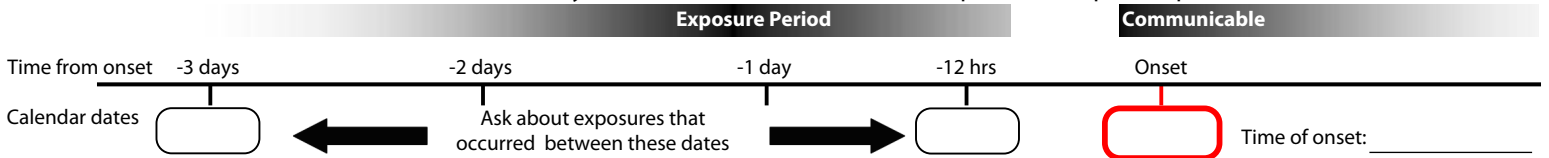
What symptoms did the patient experience? Check all that apply.

- Abdominal pain
- Nausea
- Asymptomatic
- Diarrhea
- Vomiting
- Fever/chills
- Other, specify: _____

If the patient was asymptomatic or the onset date is unknown, [skip to LONG-TERM EXPOSURE QUESTIONS section on page 5.](#)

VIII. EXPOSURE PERIOD CALCULATION

Enter onset date in red box. Count backwards 3 days from onset date to calculate the probable exposure period and enter dates in boxes.



IX. CONTACTS (Optional: contact information on page 6)

1. Were any of the patient's contacts symptomatic in the 3 days before or after this patient's onset? Yes No Unk

a. If yes, were any contacts household members? Yes No Unk

b. If yes, specify (check all that apply):

- One or more contacts had onset >24 hours **after** patient's onset (primary case = patient; secondary case = contact)
- One or more contacts had onset **within** 24 hours of patient's onset (primary case = patient and contact)
- One or more contacts had onset >24 hours **before** patient's onset (primary case = contact; secondary case = patient)
- Unknown

If the patient is [known to be a secondary case](#), this form is complete.

If the patient is [not known to be a secondary case](#), please complete the remainder of this form.

X. TRAVEL HISTORY

2. Did the patient travel during the 3 day exposure period? Yes No Unk

a. If yes, was that travel overnight? Yes No Unk

b. If yes, specify type of travel (check all that apply): In-state Out-of-state Out-of-country

c. If yes, specify travel dates and locations:

If the patient's illness was acquired [outside of the U.S.](#), this form is complete.

If the patient's illness may have been acquired [in the U.S.](#), please complete the remainder of form.

3. Did the patient consume food from any restaurant during the 3 day exposure period?

Yes No Unk

- a. If yes, specify setting (check all that apply):
- Fast-food (order at counter)
- Sit-down (waiter takes order at table)
- Self-serve buffet
- Delivery (food delivered to location)
- Other:

Please note: if a restaurant is suspected as the source of infection, please fill out the Environmental Health Foodborne Illness Survey/ Complaint Form (http://www.myfloridaeh.com/medicine/foodsurveillance/investigation_information.htm).

b. If yes, provide details (restaurant names, foods, locations, etc.):

[Empty box for providing details]

XII. CHILD/INFANT FOOD HISTORY

4. If the patient is <5 years old, did the child consume any of the following during the 3 day exposure period?

If the child is 5 years or older, skip to next page.

Yes No Unk

- a. Breast milk
b. Baby formula bought as a liquid in a can.
c. Baby formula bought as a powder
i. If yes, specify type of water used to reconstitute formula:
ii. If yes, was water boiled before using to reconstitute formula?
d. Homemade puréed/strained/mashed baby food
e. Store-bought puréed/strained/mashed baby food

If yes, was any of the milk stored (i.e. pumped)? Yes No Unk

If yes, specify brand:

If yes, specify brand:

- Unfiltered tap water Bottled water
Filtered tap water Other:

Yes No Unk

If yes, specify types:

If yes, specify brand/types:

XIII. GENERAL FOOD HISTORY (Optional: 72 hour food history on page 7)

5. Did the patient prepare or handle any raw meat during the 3 day exposure period?

Yes No Unk

If yes, specify (check all that apply): Poultry Beef Pork Fish Shellfish Other:

6. Did the patient consume any of the following during the 3 day exposure period? If yes, provide details (foods, settings, etc.).

Yes No Unk

- a. Poultry
b. Beef
c. Pork
d. Fish
e. Shellfish
f. Eggs
g. Foods with raw eggs (cake mix, salad dressings, etc.)
h. Unpasteurized milk or milk products
i. Raw or unpasteurized cheese (queso blanco, queso fresco, etc.)
j. Peanut butter
k. Nuts
l. Raw produce
If yes, specify (check all that apply): Any food from salad bar Lettuce Peppers (bell, chile, etc.) Green onions (scallions) Sprouts (bean, alfalfa, etc.) Tomatoes Cilantro Cantaloupe
m. Unpasteurized juice or cider
n. Food from produce stand, roadside vendor, mobile stand, concession stand, or truck
o. Food from speciality butcher/specialty market
p. Home slaughtered/home grown food
q. Food at a group meal (party, wedding, business meeting, potluck, etc.)
r. Food at an outdoor setting (picnic, barbecue, etc.)
s. Drink untreated/unfiltered water
If yes, specify (check all that apply): Private well Shared well Other (stream, surface water, swimming, etc), specify:

Yes No Unk

If yes, was any of it raw or undercooked?

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If yes, was any of it raw or undercooked?

If yes, was any of it raw or undercooked?

If yes, was any of it raw or undercooked?

7. Did the patient prepare or handle food for any public/private gathering while symptomatic?

Yes No Unk

If yes, provide detail:

8. Did the patient have any exposure to animals during the 3 day exposure period? Yes No Unk

a. If yes, specify animal (check all that apply):

- | | | |
|---------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Cat | <input type="checkbox"/> Lizard/iguana | <input type="checkbox"/> Caged bird |
| <input type="checkbox"/> Dog | <input type="checkbox"/> Snake | <input type="checkbox"/> Horse |
| <input type="checkbox"/> Turtle | <input type="checkbox"/> Hamster/guinea pig | <input type="checkbox"/> Cow |
| <input type="checkbox"/> Frog | <input type="checkbox"/> Duck/goose | <input type="checkbox"/> Goat/sheep |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Chicken/poultry | <input type="checkbox"/> Other: _____ |

b. If yes, specify setting (check all that apply):

- Household pet
- School or day care pet
- Farm
- Petting zoo/fair
- Wild
- Other: _____

Animal history comments:

9. Are there pets in the household? Yes No Unk

a. If yes, total number of pets: _____

b. If yes, what type of food are pets fed? Check all that apply.

- Dry food
- Fresh or frozen food
- Raw meat, bones, or eggs
- Other: _____
- Unk

c. If yes, where are pets fed? Check all that apply.

- Kitchen
- Laundry room
- Garage
- Other: _____
- Unk

d. If yes, how often does the patient clean up the pet's feces, urine, or vomit?

- Never
- On occasion
- Weekly
- Daily
- Unk

XV. OTHER ENVIRONMENTAL EXPOSURES

10. Was the patient exposed to any of the following during the 3 day exposure period? If yes, provide details.

Yes No Unk

a. Outdoor/recreational activities _____

- If yes, specify (check all that apply):
- | | | | |
|------------------------------------|---------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Playing | <input type="checkbox"/> Sports | <input type="checkbox"/> Camping | <input type="checkbox"/> Fishing |
| <input type="checkbox"/> Yard work | <input type="checkbox"/> Hiking | <input type="checkbox"/> Hunting | <input type="checkbox"/> Other: _____ |

b. Recreational water (swimming, splashing, wading, etc.) _____

- If yes, specify (check all that apply):
- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Pool | <input type="checkbox"/> Spa/hot tub/jacuzzi | <input type="checkbox"/> River/lake/canal/pond |
| <input type="checkbox"/> Kiddie pool | <input type="checkbox"/> Interactive fountain | <input type="checkbox"/> Boating/kayaking/canoeing/fishing |
| <input type="checkbox"/> Wading pool | <input type="checkbox"/> Water park | <input type="checkbox"/> Ocean/Gulf |
| <input type="checkbox"/> Other: _____ | | |

c. Close contact with a healthcare worker, daycare worker, or food handler _____

d. Contact with a diapered child or adult _____

e. Contact with children <5 years old who attend daycare, preschool, Head Start, etc. _____

f. Live in an institution (nursing home, jail, group home, etc.) _____

g. Occupational exposure to excreta (sewer plant worker, plumbers, septic tank workers, etc.) _____

11. If the patient is <5 years old, answer the following questions for the 3 day exposure period?

If the patient is 5 years or older, skip to next page.

Yes No Unk

a. Was the child in diapers?

b. Was the child toilet trained?

c. Was the child crawling?

d. Was the child walking?

e. Was the child teething?

f. Did the child use a pacifier or teething toys?

- If yes, how are they cleaned? Check all that apply.
- | | |
|---|--|
| <input type="checkbox"/> Rinsed with water | <input type="checkbox"/> Sterilized using heat (e.g. microwave or boiling) |
| <input type="checkbox"/> Washed with soap and water | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dishwasher | <input type="checkbox"/> Unk |

g. Did the child suck his/her thumb or fingers?

h. Did the child use bottles?

- If yes, how are they cleaned? Check all that apply.
- | | | |
|---|--|------------------------------|
| <input type="checkbox"/> Rinsed with water | <input type="checkbox"/> Dishwasher | <input type="checkbox"/> Unk |
| <input type="checkbox"/> Washed with soap and water | <input type="checkbox"/> Sterilized using heat (e.g. microwave or boiling) | |
| <input type="checkbox"/> Bottle brush | <input type="checkbox"/> Other: _____ | |

i. Did the child ride in a grocery cart with meat or poultry?

j. Was the child exposed to dirt or sand, either indoors or outdoors?

k. Did the child spend time on the floor? If yes, specify approximately how many hours per day:

<input type="radio"/> <1	<input type="radio"/> 7-9
<input type="radio"/> 1-3	<input type="radio"/> 10+
<input type="radio"/> 4-6	<input type="radio"/> Unk

12. In an average day:

- a. How many times does the patient wash or sanitize his/her hands?
 - <1
 - 1-3
 - 4-6
 - 7-9
 - 10+
 - Unk
- b. Does the patient use soap or hand sanitizer (e.g. Purell) more often?
 - Never uses either
 - Soap
 - Sanitizer
 - About the same
 - Unk
- c. How many 8 oz glasses of unheated tap water does the patient drink?
 - <1
 - 1-2
 - 3-4
 - 5-6
 - 6+
 - Unk
- d. How many 8 oz drinks **made with** unheated tap water does the patient drink?
 - <1
 - 1-2
 - 3-4
 - 5-6
 - 6+
 - Unk

13. In an average week:

- a. How many hours does the patient spend outdoors? This includes playing, gardening/yard work, camping/hiking, sports, running, biking, etc.
 - <1
 - 1-3
 - 4-6
 - 7-9
 - 10+
 - Unk
- b. How many frogs, lizards, turtles, or other reptiles/amphibians does the patient see around/outside the residence?
 - <1
 - 1-3
 - 4-6
 - 7-9
 - 10+
 - Unk
- c. How often are shoes worn inside the house by residents or visitors?
 - Never
 - Rarely
 - Occasionally
 - Frequently
 - Always
 - Unk
- d. How many times is a dishwasher run per week in the patient's household?
 - Never
 - 0-1
 - 2-3
 - 4-5
 - 6+
 - Unk
- e. How many meals are **prepared** per week in the patient's household?
 - <1
 - 1-3
 - 4-6
 - 7-9
 - 10+
 - Unk

14. In an average week, how often is meat (chicken, beef, pork, etc.) prepared in the patient's household (regardless of whether the patient eats the meat)?

- <1, skip to question 15
 - 1-3
 - 4-6
 - 7-9
 - 10+
 - Unk
- a. How is meat thawed before cooking? **Check all that apply.**
 - Meat is never frozen or is cooked frozen
 - Refrigerator
 - Microwave
 - Kitchen/room surface (counter, sink, etc.)
 - Under running water
 - Other: _____
 - Unk
 - b. What surfaces in the home are used to prepare meat? **Check all that apply.**
 - Wood cutting board
 - Plastic or other cutting board
 - Countertop
 - Table
 - Sink
 - Plate
 - Other: _____
 - Unk
 - c. How are surfaces cleaned after meat preparation? **Check all that apply.**
 - Surfaces are not cleaned
 - Rinsed with water
 - Washed with soap and water
 - Washed in dishwasher
 - Disinfected with bleach/other
 - Wiped with multi-use sponge/cloth
 - Wiped with single-use sponge/cloth
 - Other: _____
 - Unk

15. Regarding the patient's daily household (include patient):

- a. Total # of people: _____
- b. # of people < 5 years old: _____
- c. # of children/adults in diapers: _____
- d. # of toilets: _____

16. List jobs of all working members of household:

- a. Do any of the jobs listed above involve exposure to soil?
 - Yes
 - No
 - Unk
 - No jobs
- b. Do any of the jobs listed above involve exposure to animals?
 - Yes
 - No
 - Unk
 - No jobs

17. Regarding the patient's residence:

- a. Type of residence:
 - Free-standing house
 - Apartment building
 - Condo/townhouse/duplex
 - Mobile home
 - Other: _____
 - Unk
- b. Setting of residence:
 - Urban/city
 - Suburban residential area
 - Small town
 - Rural area
 - Other: _____
 - Unk
- c. Type of piped water source:
 - Municipal/city/public water
 - Private well
 - Community (shared) well
 - Other: _____
 - Unk
- d. Type of waste disposal:
 - Septic tank
 - Public sewer system
 - Other: _____
 - Unk
- e. Is water filtered?
 - Yes
 - No
 - Unk

If yes, what type of filter is used?
Check all that apply.

 - Pitcher filter
 - Faucet-mounted filter
 - Refrigerator filter
 - Under-the-sink filter
 - Whole-house filter
 - Other: _____
 - Unk
- f. Is there a separate system of piped water for irrigation purposes only?
 - Yes
 - No
 - Unk
- g. Do any immediate neighbors keep poultry/livestock on their property?
 - Yes
 - No
 - Unk
- h. Does the patient live near (within 3 miles) any family or industrial farms, meat processing plants, or any other animal husbandry facilities?
 - Yes
 - No
 - Unk

XVIII. 72 HOUR FOOD HISTORY (OPTIONAL)

Meal	Date: _____	Date: _____	Date: _____	Date: _____
Breakfast	<div style="border: 1px solid black; height: 150px;"></div>	<div style="border: 1px solid black; height: 150px;"></div>	<div style="border: 1px solid black; height: 150px;"></div>	<div style="border: 1px solid black; height: 150px;"></div>
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Snacks	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Lunch	<div style="border: 1px solid black; height: 150px;"></div>	<div style="border: 1px solid black; height: 150px;"></div>	<div style="border: 1px solid black; height: 150px;"></div>	<div style="border: 1px solid black; height: 150px;"></div>
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Snacks	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Dinner	<div style="border: 1px solid black; height: 150px;"></div>	<div style="border: 1px solid black; height: 150px;"></div>	<div style="border: 1px solid black; height: 150px;"></div>	<div style="border: 1px solid black; height: 150px;"></div>
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten
Snacks	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>	<div style="border: 1px solid black; height: 100px;"></div>
	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten	<input type="checkbox"/> Not eaten

Food history comments: