

Shigellosis Case Report Form

Version 1.2, March 2012

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

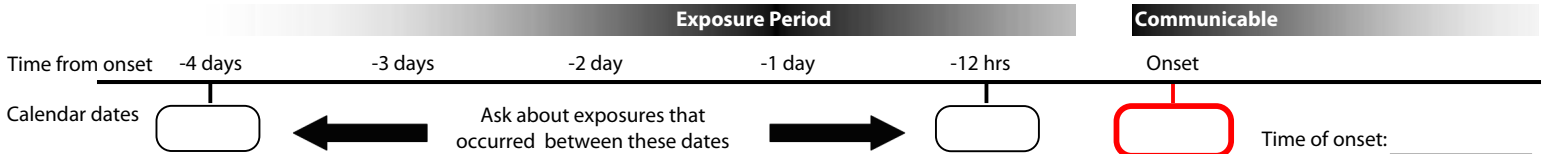
What symptoms did the patient experience? Check all that apply.

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

If the patient was [asymptomatic or the onset date is unknown](#), this form is complete.
If the patient was [symptomatic with a known onset date](#), please complete the remainder of this form.

VIII. EXPOSURE PERIOD CALCULATION

Enter onset date in red box. Count backwards 4 days from onset date to calculate the probable exposure period and enter dates in boxes.



VIX. CONTACTS (Optional: contact information on page 3)

1. Were any of the patient's contacts symptomatic in the 4 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 4 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 have contact with children who attended any of the following during the the 4 day exposure period? **If yes, provide details (facility name, dates, etc.). Optional: contact information on page 3 can be used to capture symptomatic contacts.**

Yes No Unk

- a. Daycare _____
- b. Preschool _____
- c. Elementary school _____
- d. Camp _____
- e. Other facility with children _____

4. Was the patient exposed to any of the following during the 4 day exposure period? **If yes, provide details (foods, settings, etc.).**

Yes No Unk

- a. Food from restaurants _____
- b. Raw produce _____
- c. Group meal or event (party, wedding, business meeting, potluck, etc.) _____
- d. Recreational water (swimming, splashing, wading, etc.) _____
 - i. If yes, specify Pool Spa/hot tub/jacuzzi River/lake/canal/pond Other: _____
 (check all that apply): Kiddie pool Interactive fountain Boating/kayaking/canoeing/fishing
 Wading pool Water park Ocean/Gulf
 - ii. If yes, specify name of park, recreational facility, etc. where exposure occurred: _____
- e. Drink untreated/unfiltered water _____
 If yes, specify Private well Other (stream, surface water, swimming, etc), specify: _____
 (check all that apply): Shared well
- f. Close contact with a healthcare worker, daycare worker, or food handler _____
- g. Contact with a diapered child or adult _____
- h. Live in an institution (nursing home, jail, group home, etc.) _____
- i. Occupational exposure to excreta (sewer plant worker, plumbers, septic tank workers, etc.) _____
- j. Any type of sexual contact _____

5. Did the patient prepare or handle food for any public/private gathering while symptomatic? Yes No Unk

If yes, provide detail: _____

XVII. CONTACT INFORMATION (OPTIONAL)

Obtain the following for all contacts with diarrhea in the 3 days before or after this patient's onset of illness (use contact comments for additional space):

Contact's Name	Phone number	Age (in years)	Gender	Date of onset (mm/dd/yy)	Type of contact	Sensitive situation		Confirmed case	
						Yes	No	Yes	No
_____	_____	_____	_____	_____	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
_____	_____	_____	_____	_____	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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_____	_____	_____	_____	_____	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
_____	_____	_____	_____	_____	_____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Contact comments: