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TYPHOID AND PARATYPHOID FEVER SURVEILLANCE REPORT

CDC NO.: | STATE LAB ISOLATE ID NO.

Instructions:

– Please complete this form only for new, symptomatic, culture-proven cases of typhoid or paratyphoid fever. – Form Approved OMB No. 0920-0009

DEMOGRAPHIC DATA

1. Reporting State:

2. First three letters of patient's last name:

3. Date of birth: Mo. Day Yr. ***or*** Age: (in years)

4. Sex: ☐ Male ☐ Female

5. Does the patient work as a foodhandler? ☐ Yes ☐ No ☐ Unk.

6. Citizenship: (21) ☐ U.S. ☐ Other: ☐ Unk.

CLINICAL DATA

7. Was the patient ill with typhoid or paratyphoid fever? (fever, abdominal pain, headache, etc) ☐ Yes ☐ No ☐ Unk.

If Yes, give date of onset of symptoms: Mo. Day Yr.

8. Was the patient hospitalized? ☐ Yes ☐ No ☐ Unk.

If Yes, how many days was the patient hospitalized? Days

9. Outcome of case: ☐ Recovered ☐ Died ☐ Unk.

LABORATORY DATA

10. Date *Salmonella* first isolated: Mo. Day Yr.

Site(s) of isolation: *(check all that apply)*

☐ Blood ☐ Stool ☐ Gall bladder ☐ Other (specify):

Serotype:

☐ *S.* Typhi ☐ *S.* Paratyphi A ☐ *S.* Paratyphi B ☐ *S.* Paratyphi C

11. Was **antibiotic sensitivity testing** performed on this (these) isolate(s) at the laboratory? *(Please contact the clinical laboratory for this information)* ☐ Yes ☐ No ☐ Unk.

If Yes, was the organism **resistant** to:

• Ampicillin:	☐ Yes	☐ No	☐ Not tested
• Chloramphenicol:	☐ Yes	☐ No	☐ Not tested
• Trimethoprim-sulfamethoxazole:	☐ Yes	☐ No	☐ Not tested
• Fluoroquinolones (e.g., Ciprofloxacin):	☐ Yes	☐ No	☐ Not tested

EPIDEMIOLOGIC DATA

12. Did this case occur as part of an outbreak? (two or more cases of typhoid or paratyphoid fever associated by time and place) ☐ Yes ☐ No ☐ Unk.

13. Did the patient receive typhoid vaccination (primary series or booster) within **five years** before onset of illness? ☐ Yes ☐ No ☐ Unk.

If Yes, indicate type of vaccine received:

				Year received:
• Oral Ty21a or Vivotif (Berna) four pill series:	☐ Yes	☐ No	☐ Unk.	
• ViCPS or Typhim Vi shot (Pasteur Merieux):	☐ Yes	☐ No	☐ Unk.	

14. Did the patient travel or live outside the United States during the 30 days before the illness began? ☐ Yes ☐ No ☐ Unk.

If Yes, please list in order the countries visited during the 30 days before the illness began: (other than the United States)

1. 3.
2. 4.

Date of most recent return or entry to the United States: Mo. Day Yr.

15. Was the purpose of the international travel:

a.) Business?	☐ Yes	☐ No	☐ Unk.	**d.**) Immigration to U.S.?	☐ Yes	☐ No	☐ Unk.
b.) Tourism?	☐ Yes	☐ No	☐ Unk.	**e.**) Other?	☐ Yes	☐ No	☐ Unk.
c.) Visiting relatives or friends?	☐ Yes	☐ No	☐ Unk.	(if other, specify):			

16. Was the case traced to a typhoid or paratyphoid carrier? ☐ Yes ☐ No ☐ Unk.

If Yes, was the carrier **previously known** to the health department? ☐ Yes ☐ No ☐ Unk.

17. Comments:

18. Name of Person Completing Form:

Address:

Telephone: Date: Mo. Day Yr.

– THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM –

Please send a copy to your STATE EPIDEMIOLOGY OFFICE ***and*** the FOODBORNE AND DIARRHEAL DISEASES BRANCH, CENTERS FOR DISEASE CONTROL AND PREVENTION, Mailstop A-38, Atlanta, Georgia, 30333. • Fax: (404) 639-2205

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-24, Atlanta, Georgia 30333; ATTN: PRA (0920-0009).

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