



Salmonellosis Infant Case Report Form

This form is used for patients ≤ 12 months age. Please fill this form out as completely as possible. All the necessary information from both the FoodNet Case Report Form and *Salmonella* Disease-Specific Form is included. Any information not available for NBS data entry may be useful in your investigation.

Last Name: _____ First: _____ Middle: _____ DOB: ____/____/____

PSN1 _____ TN01 CAS1 _____ TN01 State Lab Accession #: _____

FOR ADMINISTRATIVE USE

FoodNet Case? Yes No Unknown
 Was the case found during an audit*? Yes No Unknown
 Was the case interviewed by public health? Yes No Unknown
If no, was an attempt made? Yes No Unknown
 Was an exposure history obtained? Yes No Unknown

*Our FoodNet hospital visit constitutes an audit.

Date of first interview: ____/____/____

Date of first interview attempt: ____/____/____

Interviewer's Name: _____

DEMOGRAPHICS

Reported Age: _____ Days Months Years Sex: Male Female Unknown

Ethnicity: Hispanic Not Hispanic Race: American Indian / Alaskan Hawaiian / Pacific Islander Asian White Black / African American Other: _____ Refused to answer

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Did the patient immigrate to the US within 7 days of specimen collection? Yes No Unknown

Is this patient associated with a daycare facility? Yes No Unknown

If yes, specify the association: (check all that apply) Attend daycare Work/volunteer at daycare Live with daycare attendee

If yes, daycare name: _____

Is this patient a food handler? Yes No Unknown

If yes, Establishment Name: _____

LAB REPORT

Reporting Facility: _____

Ordering Facility: _____

Ordering Provider: _____

Phone Number: _____

Jurisdiction: East Tennessee West Tennessee Jackson/Madison Mid-Cumberland Upper Cumberland Memphis/Shelby Northeast Nashville/Davidson Sullivan South Central Chattanooga/Hamilton Out of Tennessee Southeast Knoxville/Knox Unassigned

Lab Report Date: ____/____/____

Date Received by Public Health: ____/____/____

Date Specimen Collected: ____/____/____

Specimen Source:

Blood Stool Urine Unknown Other: _____

Test Type: PCR EIA Culture Other: _____

INVESTIGATION

Investigation Start Date: ____/____/____

Investigator: _____

Date Assigned to Investigation: ____/____/____

Case Status: Confirmed Probable Suspect

Investigation Status: Open Closed

SYMPTOM HISTORY

Date/Time of Illness Onset: ____/____/____ ____:____ AM PM First Symptom: _____

Symptoms: Diarrhea Bloody diarrhea Constipation Vomiting Nausea Fever (Max) _____ °F
 (Check all that apply) Fatigue Chills Abdominal cramps Muscle aches Weight loss Headache
 Other: _____

If yes to diarrhea, date/time of diarrhea onset: ____/____/____ ____:____ AM PM

If yes to vomiting, date/time of vomiting onset: ____/____/____ ____:____ AM PM

As of today, is he/she still experiencing symptoms? Yes No Unknown Duration of illness: _____ Minutes Hours Days

If recovered, date/time of recovery: ____/____/____ ____:____ AM PM

CLINICAL INFORMATION/HOSPITALIZATION

Was the patient hospitalized for this illness?

Yes No Unknown

If yes, Hospital Name: _____

Admission Date: ___/___/___

Discharge Date: ___/___/___

Was the patient transferred from one hospital to another?

Yes No Unknown

If yes, specify the hospital to which the patient was transferred:

Was there a second hospitalization?

Yes No Unknown

If yes, Hospital Name: _____

Admission Date: ___/___/___

Discharge Date: ___/___/___

During any part of the hospitalization, did he/she stay in an Intensive Care Unit (ICU) or a Critical Care Unit (CCU)?

Yes No Unknown

Is the patient pregnant? Yes No Unknown

Did the patient die from this illness? Yes No Unknown

MEDICATION / HEALTH HISTORY

To better understand your illness and the factors that may affect illness, we ask a few general questions about medications and health history.

Did he/she take any antibiotics for this illness?

Yes No May Have Did Not Ask/Answer

If yes, what antibiotics did he/she take? (i.e. Amoxicillin, Bactrim, Clindamycin, Z-Pak)

In the 30 days before your illness began...

Did he/she take any antibiotics?

Yes No May Have Did Not Ask/Answer

If yes, what antibiotics did he/she take? (i.e. Amoxicillin, Bactrim, Clindamycin, Z-Pak)

Did he/she have any form of antacid?

Yes No May Have Did Not Ask/Answer

Antacids are medications to block acid, often for heartburn, indigestion or acid reflux.

If yes, what medications to block acids did he/she take? (i.e. Tums, Pepto)

Did he/she take a probiotic?

Yes No May Have Did Not Ask/Answer

In the 6 months before your illness began...

Did he/she have abdominal surgery? (i.e. removal of appendix or surgery of the stomach or large intestine, not including C-section)

Yes No May Have Did Not Ask/Answer

Were he/she diagnosed or treated for cancer? (including leukemia/lymphoma)

Yes No May Have Did Not Ask/Answer

Is he/she diabetic? (not including gestational diabetes)

Yes No Unknown Did Not Ask/Answer

TRAVEL HISTORY

Did he/she travel in the 7 days prior to onset of illness? Yes No Unknown

Destination	Date of Arrival	Date of Departure	Notes

In the 6 months before illness, did he/she travel outside the United States? Yes No May Have Did Not Ask/Answer

If yes, what countries did you visit? _____

In the 6 months before illness, did any members of his/her household travel outside the United States?

Yes No May Have Did Not Ask/Answer

If yes, what countries did your household members visit? _____

RELATED CASES

Does the patient know of any similarly ill persons (with diarrhea)? Yes No Unknown

Are there any other cases related to this one? Yes, household Yes, outbreak No, sporadic Unknown

If yes, please provide names, onset dates, contact information and any other details for similarly ill persons or related cases:

OUTBREAK/CLUSTER

Is this case part of an outbreak? Yes No Unknown

CDC cluster code: _____

Type of outbreak:

CDC NORS number: _____

- Animal contact Foodborne Person-to-person Environmental contamination (not food or water) Waterborne
 Unknown Other Indeterminate

POSSIBLE SOURCE(S) OF INFECTION DURING EXPOSURE PERIOD

These questions are about exposures your child may have had in the 7 days before you got sick. There are questions about various items, including animals, ill persons, water, special diets, special events, and various foods he/she may have come into contact with. For each of the questions, please answer yes, no, or may have.

ANIMAL CONTACT — In the 7 days before illness...

1. Did he/she work at, live on, or visit a farm, ranch or petting zoo with animals? (circle which setting)
 1A. Where? _____ When? _____

2. Did he/she come into contact with any...	Yes	No	May Have	Did Not Ask/Answer
Cats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dogs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken/turkey?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birds (non-poultry)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:				
Rodents/small mammals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reptile/amphibian?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cattle/goat/sheep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pig?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2A. Where did he/she come into contact with the animal(s)? _____ When? _____

3. Did he/she come into any contact with animal feces or manure? Yes No May Have Did Not Ask/Answer
4. Did he/she come into contact with a pet that had diarrhea? Yes No May Have Did Not Ask/Answer
5. Did he/she have any contact with dry, canned, or frozen animal feed?
 5A. Please describe: _____

PERSON-TO-PERSON

1. Did one of his/her household members or another person he/she spends a lot of time with have diarrhea in the 7 days before he/she became ill?
 1A. Who? _____ Where? _____

WATER

1. Do you use water from a private well as your primary source of drinking water? Yes No May Have Did Not Ask/Answer
2. Did he/she drink any water directly from a natural spring, lake, pond, stream, or river in the 7 days before illness? Yes No May Have Did Not Ask/Answer
3. Did he/she swim or wade in water from a natural setting (lake, river, pond, ocean, etc.) in the 7 days before illness? Yes No May Have Did Not Ask/Answer
4. Did he/she swim or wade in treated/chlorinated water (pool, hot tub, waterpark, fountain, etc.) 7 days before illness? Yes No May Have Did Not Ask/Answer

RAW MEAT HANDLING

1. Did anyone in your household handle raw poultry in the 7 days before illness? Yes No May Have Did Not Ask/Answer
2. Did anyone in your household handle raw beef in the 7 days before illness? Yes No May Have Did Not Ask/Answer
3. Did anyone in your household handle raw fish or seafood in the 7 days before illness? Yes No May Have Did Not Ask/Answer

EVENTS/ RESTAURANTS — In the 7 days before illness...

1. Did he/she attend any special events (concerts, festivals, sporting events, meetings, religious gatherings, etc.)?
 1A. What event(s)? _____ Where? _____ When? _____

2. Did he/she eat foods (even a bite) prepared outside the home (restaurants, catered events, etc.)? Yes No May Have Did Not Ask/Answer

- 2A. If yes or maybe ate out, which setting? (check all that apply)
- Fast-food (order at counter) Take-out or delivery food Bakery Other: _____
 Sit-down restaurant (order taken at table) Catered event Ice cream or dessert shop
 Self-serve buffet School or other institutional setting Coffee or tea shop

2B. Name(s) and Address(es):	Foods eaten:	When?

FOOD SOURCES AND FOOD EXPOSURES

<i>Did your food come from...</i>	Yes	No	May Have	Did Not Ask/Answer	Name(s) and Location(s)
1. Grocery stores/supermarkets?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Warehouse stores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Small markets/mini-marts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Health food, "whole food" stores, co-ops?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Farmer's markets, roadside stands, farm? (including farm shares, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Other?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

<i>In the 7 days before illness did he/she eat...</i>	Yes	No	May Have	Did Not Ask/Answer	Variety, Type, or Brand	Location Purchased or Restaurant
1. Breast milk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A	N/A
2. Powdered baby formula?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Liquid baby formula?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. Store-bought baby food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5. Other foods marketed for babies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6. Any other foods?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

OTHER COMMENTS

Is there anything else you feel may be relevant that has not already been asked?

FOR INTERVIEWER USE

At the conclusion of the interview please...

- Answer any questions
- Thank the patient for their time
- Provide hygiene and prevention education
- Notify the appropriate staff of potential outbreaks, events, or unusual information
- Exclude persons from sensitive populations until 48 hours symptom free (health/day care, food handler)
- **FoodCORE staff:** contact regional/ local health department for exclusions

INTERVIEWER COMMENTS