Foodborne Diseases Active Surveillance Network (FoodNet) Case Report Bacterial Form

Local Case ID (Medical Record #): _____ **Isolated Bacteria:** _____

Patient's name: _____
Last First

Address: _____ **Phone No**: ( ) _____ - _____
Number/ Street City State ZIP

PHLIS ID # (Patient-Specimen): □□□□□□□□-□□□□□□□□□-□□□-□□
Site ID **Patient ID** **Spec ID** **Aliquot ID**

Local ID: _____-□□□□

NEDSS ID: PSN1-□□□□□□-□□-□□ **CAS1**-□□□□□□□-□□-□□
Patient ID **State** **Installation** **Investigation ID** **State** **Installation**

1) COUNTY (residence of patient):

_____

_____

2) SEX:

☐ Male ☐ Female ☐ Unknown

3) DATE OF BIRTH:

_____ /_____ /_____
month day year

4) RACE: (original categories)

☐ **White**

☐ **Black**

☐ **American Indian/ Native Alaskan**

☐ **Unknown**

☐ **Asian or Pacific Islander**

4a) RACE: (additional FN categories)

☐ Asian

☐ Pacific Islander or Native Hawaiian

☐ Multi-racial

☐ Other

5) ETHNICITY:

☐ Hispanic

☐ Non-Hispanic

☐ Unknown

6) SPECIMEN COLLECTION DATE

_____/_____/ 200____
month day

7) AGE:_____ years

8) IF < 1 YEAR, AGE: _____ months

9) SUBMITTING LAB:

_____

_____
Laboratory

9a) SUBMITTING PHYSICIAN:

_____

Phone: ( ) _____ -_____

Informant _____ **Date Report Received in Lab** _____/_____/ 200____
month day

10) SOURCE OF SPECIMEN: ☐ Stool ☐ Blood ☐ CSF ☐ Urine ☐ Unknown ☐ Other site (specify):_____

_____

11) ISOLATED BACTERIA:

☐ ***Salmonella*** (serogroup_____) serotype_____)

☐ ***Shigella*** (serogtype/species_____)

☐ ***Campylobacter*** (species_____)

☐ ***E. coli***

Biochemically identified? ☐ Yes ☐ No ☐ Unknown

O157 positive? ☐ Yes ☐ No ☐ Unsure/Not Tested

O antigen number _____

H7 positive? ☐ Yes ☐ No ☐ Unsure/Not Tested

H Antigen Number _____

Isolate non-motile? ☐ Yes ☐ No ☐ Unsure/Not Tested

Shiga toxin-positive? ☐ Yes ☐ No ☐ Unsure/Not Tested

National database PFGE Pattern _____

☐ ***Vibrio*** (species_____)

☐ ***Yersinia*** (species_____)

☐ ***Listeria monocytogenes*** (serotype_____)

Pregnant? ☐ Yes ☐ No ☐ Unknown

Outcome of Fetus?

☐ Abortion/stillbirth

☐ Induced abortion

☐ Live birth/neonatal death

☐ Survived-clinical infection

☐ Survived-no apparent illness

☐ Unknown

☐ Other Bacteria (specify:)_____

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Data Entry: ☐ NEDSS ☐ PHLIS ☐ STATE SYSTEM ☐ CASE-CONTROL STUDY ☐ EPI INFO

A. Hospital Follow-up:

12) PATIENT STATUS AT THE TIME OF SPECIMEN COLLECTION:

☐ Hospitalized (*go to 14*) ☐ Unknown (*go to 14c*)

☐ Outpatient (*go to 13*)

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13) IF OUTPATIENT, WAS THE PATIENT SUBSEQUENTLY HOSPITALIZED?

☐ Yes (*go to14*) ☐ No (*go to 14c*) ☐ Unknown (*go to 14c*)

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14) IF PATIENT WAS HOSPITALIZED
(that is, if answered "Hospitalized" to #12 or "Yes" to #13):

Hospital name:_____

Date of first admission: _____ /_____ / 200___
month day

Date of last discharge: _____ /_____ / 200___
month day

14a) TRANSFERRED TO ANOTHER HOSPITAL?

☐ Yes ☐ No ☐ Unknown

14b) If Yes, TRANSFER HOSPITAL NAME:

_____

14c) HOW WAS THE INFORMATION (from #12,13, or 14) DETERMINED?

☐ Patient / relative contacted

☐ Physician contacted or chart review / medical records review

☐ Did not follow up

☐ County provided information

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15) OUTCOME: ☐ Alive ☐ Dead ☐ Unknown

15a) HOW WAS THIS INFORMATION (from #15) DETERMINED?

☐ Patient / relative contacted

☐ Physician contacted or chart review/medical records review

☐ Did not follow up

☐ County provided information

B. Health Department Follow-up:

If the isolate was further characterized by the State Lab, please update #11.

16) DID THE STATE LAB RECEIVE THE ISOLATE?

☐ Yes ☐ No ☐ Unknown

16a) If Yes, STATE LAB ISOLATE ID NUMBER:

_____

17) DID THE PATIENT TRAVEL OUTSIDE THE U.S. WITHIN THE LAST

- **30 days if infected with *S.* Typhi or *Listeria***
- **7 days if infected with other bacterial pathogen**

☐ Yes (*go to 17a)* ☐ No (*go to 18)* ☐ Unknown (*go to 18)*

17a)
Date of departure from the U.S. : _____ /_____ / 200___
month day

Date of return to the U.S. : _____ /_____ / 200___
month day

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18) WAS CASE FOUND DURING AN AUDIT?

☐ Yes ☐ No ☐ Unknown

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19) WAS THE CASE PART OF AN OUTBREAK?

☐ Yes (*go to 19a)* ☐ No (*go to 20)* ☐ Unknown (*go to 20)*

19a) IF OUTBREAK RELATED, WAS IT A FOODBORNE OUTBREAK?

☐ Yes (*go to 19b)* ☐ No (*go to 20)* ☐ Unknown (*go to 20)*

19b) CDC EFORS NUMBER: _____

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20) WAS CASE ENROLLED IN A CASE-CONTROL STUDY?

☐ Yes ☐ No ☐ Unknown

If No, Reason: _____

Reason Code: _____

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21) IS CASE REPORT COMPLETE? ☐ Yes ☐ No

21a) If Yes, DATE CASE REPORT COMPLETED:

_____ /_____ / 200____
month day

21b) INITIALS OF PERSON COMPLETING CASE REPORT:

_____

Comments_____

_____

_____

_____

_____

_____

_____

_____

Revised 5/17/05