TYPHOID AND PARATYPHOID FEVER SURVEILLANCE REPORT

CDC NO.: (1-5)

STATE 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: (6-7)

2. First three letters of patient's last name: (8-10)

3. Date of birth: Mo. Day Yr. (11-16) ***or*** Age: (in years) (17-18)

4. Sex: (19)
1 Male 2 Female

5. Does the patient work as a foodhandler? (20)
1 Yes 0 No 9 Unk.

6. Citizenship: (21)
1 U.S. 8 Other: _____ 9 Unk.

CLINICAL DATA

7. Was the patient ill with typhoid or paratyphoid fever? (fever, abdominal pain, headache, etc) (22)
1 Yes 0 No 9 Unk.

If Yes, give date of onset of symptoms: Mo. Day Yr. (23-28)

8. Was the patient hospitalized? (29)
1 Yes 0 No 9 Unk.

If Yes, how many days was the patient hospitalized? Days (30-31)

9. Outcome of case: (32)
1 Recovered 2 Died
9 Unk.

LABORATORY DATA

10. Date *Salmonella* first isolated: Mo. Day Yr. (33-38)

Site(s) of isolation: *(check all that apply)* (39)
1 Blood 2 Stool 3 Gall bladder 8 Other (specify): _____ (40-55)

Serotype:
S. Typhi A *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)* (56)
1 Yes 0 No 9 Unk.

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

- Ampicillin: (57) 1 Yes 0 No 9 Not tested
- Chloramphenicol: (58) 1 Yes 0 No 9 Not tested
- Trimethoprim-sulfamethoxazole: (59) 1 Yes 0 No 9 Not tested
- Fluoroquinolones (e.g., Ciprofloxacin): (60) 1 Yes 0 No 9 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) (61) 1 Yes 0 No 9 Unk.

13. Did the patient receive typhoid vaccination (primary series or booster) within **five years** before onset of illness? (62)
1 Yes 0 No 9 Unk.

If Yes, indicate type of vaccine received: Year received:

- Standard killed typhoid shot (Wyeth-Ayerst): (63) 1 Yes 0 No 9 Unk. (64-65)
- Oral Ty21a or Vivotif (Berna) four pill series: (66) 1 Yes 0 No 9 Unk. (67-68)
- ViCPS or Typhim Vi shot (Pasteur Merieux): (69) 1 Yes 0 No 9 Unk. (70-71)

14. Did the patient travel or live outside the United States during the 30 days before the illness began? (72)
1 Yes 0 No 9 Unk.

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

1. _____ (73-88)
2. _____ (89-104)
3. _____ (105-120)
4. _____ (121-136)

Date of most recent return or entry to the United States: Mo. Day Yr. (137-142)

15. Was the purpose of the international travel:

a.) Business? (143) 1 Yes 0 No 9 Unk.
b.) Tourism? (144) 1 Yes 0 No 9 Unk.
c.) Visiting relatives or friends? (145) 1 Yes 0 No 9 Unk.
d.) Immigration to U.S.? (146) 1 Yes 0 No 9 Unk.
e.) Other? (147) 1 Yes 0 No 9 Unk.

(if other, specify): _____ (148-164)

16. Was the case traced to a typhoid or paratyphoid carrier? (165) 1 Yes 0 No 9 Unk.

If Yes, was the carrier **previously known** to the health department? (166) 1 Yes 0 No 9 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