North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

North Carolina Public Health

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

BOTULISM, FOODBORNE
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 10

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fatigue or malaise or weakness ☐Y ☐N ☐U
Cranial nerve or bulbar weakness or paralysis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____/_____/_____
Please specify (select all that apply)
☐ Head drooping
☐ Blurred vision or double vision
☐ Drooping eyelids / ptosis
☐ Difficulty swallowing (dysphagia)
☐ Difficulty speaking (dysarthria)
☐ Loss of facial expression
☐ Other_____
Muscle weakness (paresis) ☐Y ☐N ☐U
Please specify
☐ Localized ☐ Generalized
Muscle paralysis ☐Y ☐N ☐U
Acute flaccid paralysis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____/_____/_____
☐ Asymmetric ☐ Symmetric
Respiratory paralysis ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____/_____/_____
EMG performed ☐Y ☐N ☐U
Date performed (mm/dd/yyyy):_____/_____/_____
Result _____
Nerve conduction study performed ☐Y ☐N ☐U
Date performed (mm/dd/yyyy):_____/_____/_____
Result _____
Head CT performed ☐Y ☐N ☐U
Date performed (mm/dd/yyyy):_____/_____/_____
Result _____

MRI performed ☐Y ☐N ☐U
Date performed (mm/dd/yyyy):_____/_____/_____
Result _____
Tensilon test performed ☐Y ☐N ☐U
Result _____
Dry mouth ☐Y ☐N ☐U
Shortness of breath/difficulty breathing/ respiratory distress ☐Y ☐N ☐U
Vomiting ☐Y ☐N ☐U
Diarrhea ☐Y ☐N ☐U
Maximum number of stools in a 24-hour period:_____
Constipation ☐Y ☐N ☐U
Dizziness (vertigo) ☐Y ☐N ☐U
Abdominal swelling ☐Y ☐N ☐U
Other symptoms, signs, clinical findings, or complications consistent with this illness ☐Y ☐N ☐U
Please specify:

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U
Specify _____
_____

REASON FOR TESTING

Why was the patient tested for this condition?
☐ Symptomatic of disease
☐ Screening of asymptomatic person with reported risk factor(s)
☐ Exposed to organism causing this disease (asymptomatic)
☐ Household contact to a person reported with this disease
☐ Other, specify:_____
☐ Unknown

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State:_____
Hospital contact name: _____
Telephone: (_____)_____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy):____/____/____

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						SSN

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? ☐Y ☐N

If yes, specify: _____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____

Survived? ☐Y ☐N ☐U
Died? ☐Y ☐N ☐U
Died from this illness? ☐Y ☐N ☐U

Date of death (mm/dd/yyyy): ____/____/____

TREATMENT

Was botulism antitoxin given? ☐Y ☐N ☐U

Date antitoxin given (mm/dd/yyyy): ____/____/____

Time treatment began _____ ☐AM ☐PM

Did the patient require mechanical ventilation? ☐Y ☐N ☐U

If yes, give details: _____

TRAVEL/IMMIGRATION

The patient is:
- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ Foreign Visitor
- ☐ Refugee
- ☐ Recent Immigrant
- ☐ Foreign Adoptee
- ☐ None of the above

Did patient have a travel history during the 48 hours prior to onset of symptoms? ☐Y ☐N ☐U

List travel dates and destinations:

From ____/____/____ to ____/____/____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐Y ☐N ☐U

List persons and contact information:

Additional travel/residency information:

CHILD CARE/SCHOOL/COLLEGE

Patient in child care? ☐Y ☐N ☐U
Patient a child care worker or volunteer in child care? ☐Y ☐N ☐U
Patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U
Is patient a student? ☐Y ☐N ☐U

Type of school:

Is patient a school WORKER / VOLUNTEER in NC school setting? ☐Y ☐N ☐U

Give details:

BEHAVIORAL RISK & CONGREGATE LIVING

During the 48 hours prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)**?** ☐Y ☐N ☐U

Name of facility: _____

Dates of contact: from ___/___/___ until ___/___/___

During the 48 hours prior to onset of symptoms, did the patient attend social gatherings or crowded settings? ☐Y ☐N ☐U

If yes, specify: _____

In what setting was the patient most likely exposed?

- ☐ Restaurant
- ☐ Home
- ☐ Work
- ☐ Child Care
- ☐ School
- ☐ University/College
- ☐ Camp
- ☐ Doctor's office/ Outpatient clinic
- ☐ Hospital In-patient
- ☐ Hospital Emergency Department
- ☐ Laboratory
- ☐ Long-term care facility /Rest Home
- ☐ Military
- ☐ Prison/Jail/Detention Center
- ☐ Place of Worship
- ☐ Outdoors, including woods or wilderness
- ☐ Athletics
- ☐ Farm
- ☐ Pool or spa
- ☐ Pond, lake, river or other body of water
- ☐ Hotel / motel
- ☐ Social gathering, other than listed above
- ☐ Travel conveyance (airplane, ship, etc.)
- ☐ International
- ☐ Community
- ☐ Other (specify) _____
- ☐ Unknown

During the 48 hours prior to onset of symptoms, did the patient use injection drugs not prescribed by a doctor? ☐Y ☐N ☐U

Specify drug(s): _____

During the 48 hours prior to onset of symptoms, did the patient use NON-injection street drugs? ☐Y ☐N ☐U

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐Y ☐N ☐U

If yes, specify:

FOOD RISK AND EXPOSURE

Where does the patient/patient's family typically buy groceries?

Store name: _____

Store city: _____

Shopping center name/address: _____

During the 48 hours prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? ☐Y ☐N ☐U

Specify source: _____

Eat any food items that came from a store or vendor where they do not typically shop for groceries? ☐Y ☐N ☐U

Specify source(s): _____

During the 48 hours prior to onset of symptoms, did the patient do any of the following:

Drink unpasteurized juices or ciders? ☐Y ☐N ☐U

Specify juices or ciders:
- ☐ Apple
- ☐ Orange
- ☐ Other, specify: _____

Eat pork/pork products? ☐Y ☐N ☐U

Specify type of pork/pork product:
- ☐ Sausage
  - ☐ Smoked ☐ Unsmoked
- ☐ Chops
- ☐ Roast
- ☐ Ham
  - ☐ Smoked ☐ Cured ☐ Canned
  - ☐ Other, specify: _____
- ☐ Bacon
- ☐ BBQ
- ☐ Other, specify: _____

Eat wild game meat (deer, bear, wild boar)**?** ☐Y ☐N ☐U

Specify type of wild game meat:
- ☐ Deer/venison
- ☐ Bear
- ☐ Wild boar/javelina/feral hog
- ☐ Other, specify: _____

Eat other meat / meat products (i.e. ostrich, emu, horse)? ☐Y ☐N ☐U

Specify other meat/meat product:
- ☐ Ostrich
- ☐ Emu
- ☐ Horse
- ☐ Other, specify: _____

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)**?** ☐Y ☐N ☐U
Handle/eat clams? ☐Y ☐N ☐U
Handle/eat crabs? ☐Y ☐N ☐U
Handle/eat lobster? ☐Y ☐N ☐U
Handle/eat mussels? ☐Y ☐N ☐U
Handle/eat oysters? ☐Y ☐N ☐U
Handle/eat shrimp? ☐Y ☐N ☐U
Handle/eat crawfish? ☐Y ☐N ☐U
Handle/eat other shellfish? ☐Y ☐N ☐U

Handle/eat finfish (i.e. Tuna, Mackerel, Skip Jack, Amber Jack, Bonito, mahi-mahi / dorado, Blue fish, Salmon, Puffer fish, Porcupine fish, Ocean sunfish, sushi)**?** ☐Y ☐N ☐U

Specify type of finfish:
- ☐ Tuna
- ☐ Mackerel
- ☐ Skip Jack or Amberjack
- ☐ Bonito
- ☐ Mahi-mahi (dorado/"blue dolphin")
- ☐ Puffer fish
- ☐ Parrot fish
- ☐ Porcupine fish
- ☐ Ocean sunfish (Mola mola)
- ☐ Bluefish
- ☐ Salmon
- ☐ Sushi, unknown type of fish
- ☐ Other: specify _____
- ☐ Unknown

CONTINUED ON NEXT PAGE

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						SSN

FOOD RISK AND EXPOSURE (CONTINUED)

During the 48 hours prior to onset of symptoms, did the patient:

Handle/eat other seafood (i.e. octopus, squid) **or frogs?** ☐Y ☐N ☐U

Specify other seafood:
☐ Squid ☐ Octopus ☐ Frog
☐ Other, specify:_____

Eat raw salads or vegetables other than sprouts? ☐Y ☐N ☐U

Specify raw salad or vegetable:
☐ Bagged salad greens without toppings, type: _____
☐ Salad with toppings, specify: _____
☐ Lettuce, type: _____
☐ Spinach
☐ Tomatoes, type: _____
☐ Cucumbers
☐ Mushrooms, type: _____
☐ Onions, type: _____
☐ Potatoes, type:_____
☐ Other, specify: _____

Eat sprouts? ☐Y ☐N ☐U

Specify type of sprouts:
☐ Alfalfa ☐ Clover ☐ Bean
☐ Other, specify: _____
☐ Unknown

Eat fresh herbs? ☐Y ☐N ☐U

Specify:
☐ Basil ☐ Thyme
☐ Parsley ☐ Cilantro
☐ Oregano ☐ Rosemary
☐ Cumin
☐ Other, specify: _____

Eat prepackaged, processed meat/meat products (does not include dried, smoked, or preserved products)**?** ☐Y ☐N ☐U

Specify type of prepackaged, processed meat/meat product:
☐ Hot dogs
☐ Cold Cuts
☐ Bologna
☐ Turkey
☐ Ham
☐ Other cold cut, specify _____

Any other ready-to-eat meat? Specify:

Eat ready-to-eat dried, preserved, smoked, or traditionally prepared meat (i.e. summer sausage, salami, jerky)**?** ☐Y ☐N ☐U

Specify type of prepared meat:
☐ Summer sausage, specify: _____
☐ Salami
☐ Jerky
☐ Other, specify: _____

Eat deli-sliced (not pre-packaged) **meat?** ☐Y ☐N ☐U

Specify type of meat:
☐ Bologna
☐ Turkey
☐ Ham
☐ Roast beef
☐ Chicken
☐ Other, specify_____

Eat meat stews or meat pies? ☐Y ☐N ☐U
Specify: _____

Eat gravy (i.e. beef, chicken, turkey)**?** ☐Y ☐N ☐U
Specify: _____

Eat potentially hazardous foods (i.e. pastries, custards, salad dressings)**?** ☐Y ☐N ☐U

Specify:
☐ Pastries
☐ Custards
☐ Salad dressings
☐ Other: specify _____

Eat commercially-prepared, refrigerated foods (i.e. dips, salsa, sandwiches)? ☐Y ☐N ☐U

Specify type of food:
☐ Dips, specify:_____
☐ Salsa
☐ Sandwiches, Specify: _____
☐ Other, Specify: _____

Eat baked potatoes/sweet potatoes? ☐Y ☐N ☐U

Eat preserved, smoked, salted, fermented, or traditionally-prepared fish? ☐Y ☐N ☐U

Eat uneviscerated (entrails left in) **fish?** ☐Y ☐N ☐U

Eat vacuum-packed (modified atmosphere packing) **foods?** ☐Y ☐N ☐U

Eat foods stored in oil? ☐Y ☐N ☐U

Eat foods that were processed/ canned at home? ☐Y ☐N ☐U

Ingest/consume water or a drink made from water? ☐Y ☐N ☐U

Ingest breast milk? ☐Y ☐N ☐U

Ingest infant formula? ☐Y ☐N ☐U

Eat commercial baby food? ☐Y ☐N ☐U

Ingest honey (i.e. via honey-filled pacifier, honey-water)**?** ☐Y ☐N ☐U

Ingest molasses? ☐Y ☐N ☐U

Ingest corn syrup? ☐Y ☐N ☐U

Eat a known contaminated food product? ☐Y ☐N ☐U

Specify: _____

Eat at a group meal? ☐Y ☐N ☐U

Specify:
☐ Place of Worship
☐ School:
☐ Social function
☐ Other, specify:
Name:_____
Location:_____

Eat food from a restaurant? ☐Y ☐N ☐U
Name:_____
Location:_____

Notes:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed? ☐Y ☐N ☐U

Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others? ☐Y ☐N ☐U

Who was interviewed?

Were health care providers consulted? ☐Y ☐N ☐U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ☐Y ☐N ☐U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:
☐ In NC
City _____
County_____
☐ Outside NC, but within US
City _____
State _____
County_____
☐ Outside US
City _____
Country _____
☐ Unknown

Is the patient part of an outbreak of this disease? ☐Y ☐N

Notes:

Botulism, Foodborne *(Clostridium botulinum)*

2011 Case Definition

CSTE Position Statement Number: 10-ID-03

Clinical description

Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

Laboratory criteria for diagnosis

- Detection of botulinum toxin in serum, stool, or patient's food, or
- Isolation of Clostridium botulinum from stool

Case classification

Probable: A clinically compatible case with an epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours).

Confirmed: A clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons who have laboratory-confirmed botulism.