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

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

BOTULISM, INTESTINAL (INFANT)
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 110

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)
☐ Altered or weak cry
☐ 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:

Was botulism immune globulin (BabyBIG) given? ☐Y ☐N ☐U
Date immune globulin given (mm/dd/yyyy):____/____/____
Time immune globulin began_____☐AM ☐PM
Did the patient require supplemental oxygen? ☐Y ☐N ☐U
Date started (mm/dd/yyyy):____/____/____
Did the patient require mechanical ventilation? ☐Y ☐N ☐U
Date started (mm/dd/yyyy):____/____/____
Number of days on mechanical ventilation:_____

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U
Specify _____
_____
Gastrointestinal disease ☐Y ☐N ☐U
Gastric surgery or gastrectomy ☐Y ☐N ☐U

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):____/____/____

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):_____/_____/_____

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

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 30 days 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

Name of care provider: _____

City:_____State: _____

OTHER EXPOSURE INFORMATION

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

If yes, specify:

BEHAVIORAL RISK & CONGREGATE LIVING

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

FOOD RISK AND EXPOSURE

During the 30 days prior to onset of symptoms:

Did the patient drink any bottled water? ☐ Y ☐ N ☐ U

Describe the source of drinking water used in the patient's home (check all that apply**):**
- ☐ Bottled water supplied by a company
- ☐ Bottled water purchased from a grocery store
- ☐ Municipal supply (city water)
- ☐ Well water

Did the patient ingest breast milk? ☐ Y ☐ N ☐ U

Source of milk: _____

Did the patient ingest infant formula? ☐ Y ☐ N ☐ U

Type: _____

Did the patient eat commercial baby food? ☐ Y ☐ N ☐ U

Type: _____

During the 30 days 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: _____

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 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 meat stews or meat pies? ☐ Y ☐ N ☐ U

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 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:_____

Eat food from a restaurant? ☐ Y ☐ N ☐ U

Name: _____

Location: _____

Additional notes, including information about infant formula, infant baby foods, and/or breast milk:

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, Infant *(Clostridium botulinum)*

2011 Case Definition

CSTE Position Statement Number: 10-ID-03

Clinical description

An illness of infants, characterized by constipation, poor feeding, and “failure to thrive” that may be followed by progressive weakness, impaired respiration, and death.

Laboratory criteria for diagnosis

- Detection of botulinum toxin in serum or stool, or
- Isolation of Clostridium botulinum from stool

Case classification

Confirmed: A clinically compatible case that is laboratory-confirmed, occurring in a child aged less than 1 year.