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, WOUND
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 111

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
Date performed (mm/dd/yyyy):____/____/____
Result _____
Abscess/infected skin lesion (pyoderma) ☐Y ☐N ☐U
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 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:_____

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U
Specify _____
Injury/Wound/Break in skin ☐Y ☐N ☐U
Recent/Acute injury(ies) or wound(s) ☐Y ☐N ☐U
Date (mm/dd/yyyy):____/____/____
Anatomic site_____
Was medical care obtained for this injury? ☐Y ☐N ☐U
Contaminated ☐Y ☐N ☐U

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 / close contact to a person reported with this disease
☐ Other, specify_____
☐ Unknown

ISOLATION/QUARANTINE/CONTROL MEASURES

Did local health director or designee implement additional control measures? ☐Y ☐N
If yes, specify: _____

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

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):_____/_____/_____

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):____/____/____

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 14 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:

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

OTHER EXPOSURE INFORMATION

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

If yes, specify:

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, Wound *(Clostridium botulinum)*

2011 Case Definition

CSTE Position Statement Number: 10-ID-03

Clinical description

An illness resulting from toxin produced by Clostridium botulinum that has infected a wound. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

Laboratory criteria for diagnosis

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

Case classification

Confirmed: A clinically compatible case that is laboratory confirmed in a patient who has no suspected exposure to contaminated food and who has a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms.

Probable: A clinically compatible case in a patient who has no suspected exposure to contaminated food and who has either a history of a fresh, contaminated wound during the 2 weeks before onset of symptoms, or a history of injection drug use within the 2 weeks before onset of symptoms.