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

North Carolina Public Health

TYPHOID FEVER, ACUTE

Confidential Communicable Disease Report—Part 2

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

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:
Fever ☐Y ☐N ☐U
☐ Yes, subjective ☐ No
☐ Yes, measured ☐ Unknown
Highest measured temperature_____
Fever onset date (mm/dd/yyyy):_____
Fatigue or malaise or weakness ☐Y ☐N ☐U
Loss of appetite (anorexia) ☐Y ☐N ☐U
Altered mental status ☐Y ☐N ☐U
Sweats (diaphoresis) ☐Y ☐N ☐U
Night sweats ☐Y ☐N ☐U
Headache ☐Y ☐N ☐U
Cough ☐Y ☐N ☐U
Onset date (mm/dd/yyyy):_____
Productive ☐Y ☐N ☐U
Enlarged spleen (splenomegaly) ☐Y ☐N ☐U
Rose spots ☐Y ☐N ☐U
Parotidis ☐Y ☐N ☐U
Constipation ☐Y ☐N ☐U
Partial hearing loss ☐Y ☐N ☐U
Abdominal pain or cramps ☐Y ☐N ☐U
Diarrhea ☐Y ☐N ☐U
Describe (select all that apply)
☐ Bloody ☐ Non-bloody
☐ Watery ☐ Other
Maximum number of stools in a 24-hour period:_____
During the 60 days prior to onset of symptoms, was the patient:
Employed as food worker? ☐Y ☐N ☐U
Where employed?_____
Specify job duties:_____
What dates did the patient work?
_____

During the 60 days prior to onset of symptoms, was the patient: Employed as food worker while symptomatic? ☐Y ☐N ☐U
Where did the patient work?_____
What dates did the patient work?
_____
What day did the patient return to food service work?
Date:_____
Where did patient return to work?_____
A non-occupational food worker? (e.g. potlucks, receptions) during contagious period ☐Y ☐N ☐U
Where employed?_____
Specify dates worked during contagious period:
_____
A health care worker or child care worker handling food or medication in the contagious period ? ☐Y ☐N ☐U
Where employed?_____
Specify dates worked during contagious period:
_____
Comments:

PREDISPOSING CONDITIONS

Any immunosuppressive conditions ☐Y ☐N ☐U
Please specify:_____
Previously known typhoid carrier ☐Y ☐N ☐U
Other underlying illness ☐Y ☐N ☐U
Specify:_____
Receiving treatment or taking any medications ☐Y ☐N ☐U
☐ Immunosuppressive therapy, including anti-rejection therapy
Specify_____
Was medication taken/therapy provided within the last 30 days before this illness? ☐Y ☐N ☐U
For what medical condition?_____

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

TREATMENT

Did the patient take an antibiotic for this illness? ☐Y ☐N ☐U
Specify antibiotic name:_____
Date antibiotic ended:_____

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

Restrictions to movement or freedom of action? ☐Y ☐N

Check all that apply:

☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify

_____

Date control measures issued: _____

Date control measures ended: _____

Was patient compliant with control measures? ☐Y ☐N

Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.) ☐Y ☐N

If yes, specify: _____

_____

Were written isolation orders issued? ☐Y ☐N

If yes, where was the patient isolated? _____

_____

Date isolation started? _____

Date isolation ended? _____

Was the patient compliant with isolation? ☐Y ☐N

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): _____/_____/_____

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 60 days prior to onset of symptoms? ☐Y ☐N ☐U

List travel dates and destinations _____

_____

_____

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 60 days 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: _____

During the 60 days 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 60 days prior to onset, did the patient have sexual contact with a known carrier of this disease? ☐Y ☐N ☐U

Did the partner(s) become ill with the same symptoms? ☐Y ☐N ☐U

Since disease onset, has the patient had sexual contact with other(s)? ☐Y ☐N ☐U

Did the partner(s) become ill with the same symptoms? ☐Y ☐N ☐U

HEALTH CARE FACILITY AND BLOOD & BODY FLUID EXPOSURE RISKS

During the 60 days prior to onset of symptoms, did the patient work or volunteer in a health care or clinical setting? ☐Y ☐N ☐U

Facility name _____

City _____ State _____

Country _____

Occupation:

☐ Physician
☐ Physician's assistant or nurse practitioner
☐ Nurse
☐ Laboratory
☐ Other _____
☐ Unknown

Specify work setting or volunteer duties _____

_____

_____

OTHER EXPOSURE INFORMATION

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

If yes, specify:

During the 60 days prior to onset of symptoms did the patient have contact with sewage or human excreta? ☐Y ☐N ☐U

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
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FOOD RISK AND EXPOSURE

During the 60 days prior to onset of symptoms, did the patient eat any raw or undercooked meat or poultry? ☐Y ☐N ☐U

Specify meat/poultry:_____

Specify place of exposure: _____

During the 60 days prior to onset of symptoms did the patient eat any raw or undercooked seafood or shellfish (i.e., raw oysters, sushi, etc.)? ☐Y ☐N ☐U

Specify type of seafood/shellfish_____

Specify place of exposure_____

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

Does the patient have a water softener or water filter installed inside the house to treat their water? ☐Y ☐N ☐U

During the 60 days prior to onset of symptoms, did the patient drink any bottled water? ☐Y ☐N ☐U

Specify type/brand _____

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

Store name:_____

Store city: _____

Shopping center name/address:

_____

During the 60 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: _____

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): _____

Drink unpasteurized milk? ☐Y ☐N ☐U

Specify type of milk:
☐ Cow
☐ Goat
☐ Sheep
☐ Other, specify: _____
☐ Unknown

Eat any other unpasteurized dairy products? ☐Y ☐N ☐U

Specify type of product:
☐ Queso fresco, Queso blanco or other Mexican soft cheese
☐ Butter
☐ Cheese from raw milk, specify:_____
☐ Food made from raw dairy product, specify:_____
☐ Other, specify: _____

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

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

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

Eat raw fruit? ☐Y ☐N ☐U

Specify raw fruit:
☐ Apples
☐ Bananas
☐ Oranges
☐ Grapes, specify:_____
☐ Pears
☐ Peaches
☐ Berries, specify_____
☐ Melon,specify_____
☐ Mangoes
☐ 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 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 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:_____

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: _____

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 regarding setting of exposure:

VACCINE

Has patient / contact ever received vaccine related to this disease? ☐Y ☐N ☐U

Vaccine type:_____

Date last dose received (mm/dd/yyyy):_____

Source of vaccine information:

☐ Patient's or Parent's verbal report
☐ Physician
☐ Medical record
☐ Certificate of immunization record
☐ Patient vaccine record
☐ School record
☐ Other, specify:_____
☐ Unknown