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

North Carolina Public Health

TYPHOID, CARRIER (SALMONELLA TYPHI)

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
Sweats (diaphoresis) ☐ Y ☐ N ☐ U
Night sweats ☐ Y ☐ N ☐ U
Headache ☐ 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:_____

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
☐ Prior positive test
Positive test date_____
☐ Other, specify_____
☐ Unknown

TREATMENT

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

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):____/____/____

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):_____/_____/_____

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

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 4+ months after acute typhoid fever onset? ☐ 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 4+ months after acute typhoid fever onset 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 4+ months after acute typhoid fever onset, 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

OTHER EXPOSURE INFORMATION

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

If yes, specify:

FOOD RISK AND EXPOSURE

During the 4+ months after acute typhoid fever onset, was the patient:

Employed as food worker? ☐ Y ☐ N ☐ U

Where employed?_____

Specify job duties:_____

What dates did the patient work?

_____

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?_____

Anon-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:

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

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: