

**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.

**FOODBORNE DISEASE: CLOSTRIDIUM PERFRINGENS  
Confidential Communicable Disease Report—Part 2**

**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 \_\_\_\_\_  
 Unit:  Fahrenheit  Centigrade  
 Fever onset date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

**Fatigue or malaise or weakness**  Y  N  U  
**Dehydration**  Y  N  U  
 Signs of dehydration (choose all that apply):  
 Decreased skin turgor  
 Dry mucous membranes  
 Non-palpable pulse  
 Sunken eyes  
 Decreased urine output

**Prostration**  Y  N  U  
**Headache**  Y  N  U  
**Muscle aches/pains (myalgias)**  Y  N  U  
**Hypotension**  Y  N  U  
 Lowest recorded blood pressure \_\_\_\_\_

**Nausea**  Y  N  U  
**Vomiting**  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 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): \_\_\_/\_\_\_/\_\_\_

**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): \_\_\_/\_\_\_/\_\_\_

**TRAVEL/IMMIGRATION**

The patient is:  
 Resident of North Carolina  
 Resident of another state or US territory  
 None of the above

Did patient have a travel history during the 24 hours prior to onset of symptoms?  Y  N  U  
 Travel dates: From: \_\_\_\_\_ until \_\_\_\_\_  
 To city: \_\_\_\_\_  
 To country: \_\_\_\_\_

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

**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: \_\_\_\_\_

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

**BEHAVIORAL RISK & CONGREGATE LIVING**

During the 24 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: \_\_\_\_\_

During the 24 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?
- |   |  |
|---|--|
| <input type="checkbox"/> Restaurant                         | <input type="checkbox"/> Place of Worship                          |
| <input type="checkbox"/> Home                               | <input type="checkbox"/> Outdoors, including woods or wilderness   |
| <input type="checkbox"/> Work                               | <input type="checkbox"/> Athletics                                 |
| <input type="checkbox"/> Child Care                         | <input type="checkbox"/> Farm                                      |
| <input type="checkbox"/> School                             | <input type="checkbox"/> Pool or spa                               |
| <input type="checkbox"/> University/College                 | <input type="checkbox"/> Pond, lake, river or other body of water  |
| <input type="checkbox"/> Camp                               | <input type="checkbox"/> Hotel / motel                             |
| <input type="checkbox"/> Doctor's office/ Outpatient clinic | <input type="checkbox"/> Social gathering, other than listed above |
| <input type="checkbox"/> Hospital In-patient                | <input type="checkbox"/> Travel conveyance (airplane, ship, etc.)  |
| <input type="checkbox"/> Hospital Emergency Department      | <input type="checkbox"/> International                             |
| <input type="checkbox"/> Laboratory                         | <input type="checkbox"/> Community                                 |
| <input type="checkbox"/> Long-term care facility /Rest Home | <input type="checkbox"/> Other (specify) _____                     |
| <input type="checkbox"/> Military                           | <input type="checkbox"/> Unknown                                   |
| <input type="checkbox"/> Prison/Jail/Detention Center       |  |

**FOOD RISK AND EXPOSURE**

During the 24 hours 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 24 hours 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? \_\_\_\_\_

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? \_\_\_\_\_  
 Non-occupational food worker? (e.g. potlucks, receptions) during contagious period?  Y  N  U  
 Where employed? \_\_\_\_\_  
 Specify dates worked during contagious period: \_\_\_\_\_

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: \_\_\_\_\_

**FOOD RISK AND EXPOSURE (continued)**

During the 24 hours prior to onset of symptoms, did the patient:

Handle raw meat other than poultry?  Y  N  U  
 Specify type of meat:  
 Beef (hamburger/steak, etc)  
 Pork (ham, bacon, pork chops, sausage, etc)  
 Lamb/mutton  
 Wild game, specify: \_\_\_\_\_  
 Other, specify: \_\_\_\_\_  
 Unknown

Handle raw poultry?  Y  N  U  
 Specify type of poultry:  
 Chicken  
 Turkey  
 Other, specify: \_\_\_\_\_  
 Unknown

Eat ground beef/hamburger?  Y  N  U  
 Eat other beef/beef products?  Y  N  U  
 Roast  
 Steak  
 Other, specify: \_\_\_\_\_

Eat any poultry/poultry product?  Y  N  U  
 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: \_\_\_\_\_

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 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: \_\_\_\_\_

**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 \_\_\_\_\_

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

Notes regarding setting of exposure: \_\_\_\_\_