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.

SHIGELLOSIS
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
Highest measured temperature_____
Fever onset date (mm/dd/yyyy):____/____/____
How taken: _____
Chills or rigors ☐Y ☐N ☐U
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:_____
Bacteremia ☐Y ☐N ☐U
If yes, date of positive blood culture (mm/dd/yyyy):____/____/____
Other symptoms, signs, clinical findings, or complications consistent with this illness? ☐Y ☐N ☐U
If yes, specify: _____
Is patient in child care? ☐Y ☐N ☐U
Name of care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Contact name:_____
Telephone: (_____) _____

Patient wears diapers or shares a classroom with diapered children? ☐Y ☐N ☐
Who wears diapers?
☐ Patient ☐ Classmate
Give names of all child health care arrangements attended by the patient that involve diapering (patient wears diapers or other children in the same group wear diapers).
_____
_____
Is patient a child care worker or volunteer in child care? ☐Y ☐N ☐U
Name of child care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Contact name:_____
Telephone: (_____) _____
Is patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U
Name of child care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Contact name:_____
Telephone: (_____) _____
Is patient a student? ☐Y ☐N ☐U
Type of school:
☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College/College/University
☐ Other academic institution (i.e. trade school, professional school, etc)
Name: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Contact name:_____
Telephone: (_____) _____
Specify grade: _____
Is patient a school WORKER / VOLUNTEER in NC school setting? ☐Y ☐N ☐U
Type of school
☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College/College/University
☐ Other academic institution (i.e. trade school, professional school, etc)
Name: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Telephone: (_____) _____

Notes:

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PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U

Specify:

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 patient take an antibiotic as treatment for this illness? ☐Y ☐N ☐U

Specify antibiotic name:

_____

Date anitbiotic began (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):____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

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

Check all that apply:

- ☐ Work
- ☐ Child care
- ☐ School
- ☐ Sexual behavior
- ☐ Blood and body fluid
- ☐ 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

Were written quarantine orders issued? ☐Y ☐N

If yes, where was the patient quarantined?

_____

Date quarantine started: ____/____/____

Date quarantine ended: ____/____/____

Was the patient compliant with quarantine? ☐Y ☐N

BEHAVIORAL RISK & CONGREGATE LIVING

During the 7 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:

From _____/_____/_____ to _____/_____/_____

During the 7 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

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 7 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:

OTHER EXPOSURE INFORMATION

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

If yes, specify:

During the 7 days prior to onset of symptoms did the patient have contact with sewage or human excreta? ☐Y ☐N ☐U

FOOD RISK AND EXPOSURE

During the 7 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 7 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 7 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): _____

During the 7 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?

From _____/_____/_____ to _____/_____/_____

Employed as food worker while symptomatic? ☐Y ☐N ☐U

Where did the patient work? _____

What dates did the patient work?

From _____/_____/_____ to _____/_____/_____

What day did the patient return to food service work?

Date: _____

Where did patient return to work?_____

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

FOOD RISK AND EXPOSURE (CONTINUED)

During the 7 days prior to onset of symptoms, was the patient: Non-occupational food worker (e.g. potlucks, receptions) during contagious period**?** ☐Y ☐N ☐U

Where employed?_____

Specify dates worked during contagious period:

From _____/_____/_____ to _____/_____/_____

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:

From _____/_____/_____ to _____/_____/_____

During the 7 days prior to onset of symptoms, did the patient:

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 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:_____

Notes:

WATER EXPOSURE

During the 7 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water, including aerosolized water in household, community or health care settings? ☐Y ☐N ☐U

Activity(ies):

- ☐ Playing, wading, splashing
- ☐ Swimming
- ☐ Other, specify_____

Notes:

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 ☐U

Notes: