

**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
NC DISEASE CODE: 11**

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 / /



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 _____

Unknown

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

Notes regarding setting of exposure: _____

Foodborne disease: *Clostridium perfringens*

2007 Case Definition (North Carolina)

Clinical description

An illness characterized by acute onset of some or all of the following symptoms: colic, nausea, and diarrhea; vomiting and fever are usually absent. Symptom onset occurs within 24 hours following ingestion of food contaminated with toxins produced by *Clostridium perfringens*.

Laboratory criteria for diagnosis

- Isolation of *Clostridium perfringens* from clinical stool specimen or
- Demonstration of enterotoxins produced by *Clostridium perfringens* in a stool sample
- Isolation of *Clostridium perfringens* from a leftover food sample
- Positive *Clostridium perfringens* toxin assay in a leftover food sample

Case classification

Confirmed:

- a clinically compatible case with a positive culture for *Clostridium perfringens* in a stool specimen,
or
- a clinically compatible case with demonstration of enterotoxins produced by *Clostridium perfringens* in a stool specimen

Probable:

- a clinically compatible case epidemiologically linked to a confirmed case, **or**
- a clinically compatible case who provides a leftover food sample that
 - cultures positive for *Clostridium perfringens*,
or
 - tests positive for *Clostridium perfringens* toxin