

**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: OTHER/UNKNOWN
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 13**

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: _____

During the 10 days prior to onset of symptoms, did the patient 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 10 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? _____
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: _____

During the 10 days prior to onset of symptoms, did the patient have exposure to animals (includes animal tissues, animal products, or animal excreta)? Y N U
Household pets? Y N U
 Specify pet(s): _____
 Was pet vaccinated for rabies? Y N U
 Was pet sick? Y N U
 Was pet free-ranging? Y N U
 Were fleas seen on pet? Y N U
 Were ticks seen on pet? Y N U
Was patient exposed to animals associated with agriculture or aviculture (domestic/semi-domestic animals)? Y N U
 Specify animal(s): _____
During the 14 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
 If yes, describe in detail giving type of activity, water, route of exposure, water sources, factors contributing to water contamination, and any water treatment methods:

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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

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

OTHER EXPOSURE INFORMATION

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

If yes, specify: _____

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): ____/____/____

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

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: _____

CLINICAL OUTCOMES

Survived? Y N U

Died? Y N U

Died from this illness? Y N U

Date of death (mm/dd/yyyy): ____/____/____

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

TRAVEL/IMMIGRATION

The patient is:

Resident North Carolina

Resident of another state or US territory

None of the above

Did patient have a travel history during the 10 days prior to onset of symptoms? Y N U

Travel dates: From: _____ until _____

To city: _____

To country: _____

Mode(s) of transportation (check all that apply):

Airplane

Ship/boat/ferry

Automobile/motorcycle

Other

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

Name: _____

Additional travel/residency information:

HEALTH CARE FACILITY AND BLOOD & BODILY FLUID EXPOSURE RISKS

During the 10 days prior to onset of symptoms, did the patient have any of the following health care exposures?

Hospitalized

Long term care facility - resident (e.g. nursing home, rest home, rehab)

Worked or volunteered in health care or clinical setting

No

Unknown

Visit / admit date (mm/dd/yyyy): _____

Has patient been discharged? Y N U

Facility name _____

Was facility notified regarding ill patient?..... Y N U N/A

Name of person notified _____

Date notified (mm/dd/yyyy): _____

BEHAVIORAL RISK & CONGREGATE LIVING

During the 10 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 10 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?

<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	

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FOOD RISK AND EXPOSURE

During the 10 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 10 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 period of interest, 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 10 days prior to onset of symptoms, was the patient 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: _____

During the 10 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: _____

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

Handle shell eggs? Y N U

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: _____

Eat ground beef/hamburger? Y N U

Eat other beef/beef products? Y N U

Specify type:

- Roast
- Steak
- Other, specify: _____

Eat any poultry/poultry product? Y N U

Specify type:

- Chicken
- Turkey
- Other, specify: _____
- Unknown

Eat eggs or any dish having eggs as an ingredient? Y N U

Taste/eat any uncooked batter (uncooked cake/cookie batter, ice cream containing cookie dough) containing eggs? 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: _____

Other, specify: _____

Other, specify: _____

Other, specify: _____

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Other, specify: _____

Other, specify: _____

Other, specify: _____

Other, specify: _____

Handle/eat other seafood (i.e. octopus, squid) or frogs? Y N U

Specify other seafood:

- Squid Octopus Frog
- Other, specify: _____

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 prepackaged, processed meat/meat products (does not include dried, smoked, or preserved products)? Y N U

Specify type of prepackaged, processed meat/meat product:

- Hot dogs
- Cold Cuts
- Bologna
- Turkey
- Ham
- Other cold cut, specify _____

Any other ready-to-eat meat? Specify: _____

Eat ready-to-eat dried, preserved, smoked, or traditionally prepared meat (i.e. summer sausage, salami, jerky)? Y N U

Specify type of prepared meat:

- Summer sausage, specify: _____
- Salami
- Jerky
- Other, specify: _____

Eat deli-sliced (not pre-packaged) meat? Y N U

Specify type of meat:

- Bologna
- Turkey
- Ham
- Roast beef
- Chicken
- Other, specify _____

CONTINUED ON NEXT PAGE

Foodborne disease: other/unknown

2007 Case Definition (North Carolina)

Clinical description

There is no one syndrome that is foodborne illness. More than 250 different foodborne diseases have been described. Most of these diseases are infections, caused by a variety of bacteria, viruses, and parasites that can be foodborne. Other diseases are poisonings, caused by harmful toxins such as staphylococcal or botulinum toxin or chemicals that have contaminated the food. While there are many different illnesses and pathogens that could be involved, the first symptoms are usually nausea, vomiting, abdominal cramps and diarrhea.

North Carolina does disease specific surveillance for the following food and waterborne diseases: Botulism, Campylobacter infection, Cholera, CJD, Cryptosporidiosis, Cyclosporiasis, *E.coli* shiga-toxin producing infection, *Clostridium perfringens*, foodborne: staphylococcal, foodborne:ciguatera, foodborne: mushroom toxicity, foodborne: scombroid fish, Hepatitis A, Listeriosis, Salmonellosis, Shigellosis, Trichinosis, Typhoid Fever, and Vibrio infection. If individual cases or outbreaks are recognized due to any of these reportable conditions, please report them accordingly using the appropriate surveillance forms.

In addition to specific foodborne disease surveillance, all outbreaks of foodborne disease are reportable, regardless of the pathogen involved. Report cases as other/unknown whenever foodborne transmission is documented or suspected and the responsible agent is either unknown or not routinely reportable.

To be considered a foodborne disease, the microbe or toxin must enter the gastrointestinal tract through ingestion (food or water source), not through person-to-person transmission.

Laboratory criteria for diagnosis

- Isolation of infectious agent or toxin compatible with symptoms from any clinical specimen

Case classification

Confirmed: a case that is laboratory confirmed

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case