

**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.

**BOTULISM, FOODBORNE  
Confidential Communicable Disease Report—Part 2  
NC DISEASE CODE: 10**

**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:**

Fatigue or malaise or weakness  Y  N  U  
 Cranial nerve or bulbar weakness or paralysis  Y  N  U  
 Onset date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Please specify (select all that apply)  
 Head drooping  
 Blurred vision or double vision  
 Drooping eyelids / ptosis  
 Difficulty swallowing (dysphagia)  
 Difficulty speaking (dysarthria)  
 Loss of facial expression  
 Other \_\_\_\_\_

Muscle weakness (paresis)  Y  N  U  
 Please specify  Localized  Generalized

Muscle paralysis  Y  N  U  
 Acute flaccid paralysis  Y  N  U  
 Onset date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Asymmetric  Symmetric

Respiratory paralysis  Y  N  U  
 Onset date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_

EMG performed  Y  N  U  
 Date performed (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Result \_\_\_\_\_

Nerve conduction study performed  Y  N  U  
 Date performed (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Result \_\_\_\_\_

Head CT performed  Y  N  U  
 Date performed (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Result \_\_\_\_\_

MRI performed  Y  N  U  
 Date performed (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Result \_\_\_\_\_

Tension test performed  Y  N  U  
 Result \_\_\_\_\_

Dry mouth  Y  N  U  
 Shortness of breath/difficulty breathing/  
 respiratory distress  Y  N  U  
 Vomiting  Y  N  U  
 Diarrhea  Y  N  U  
 Maximum number of stools in a 24-hour period: \_\_\_\_\_  
 Constipation  Y  N  U  
 Dizziness (vertigo)  Y  N  U  
 Abdominal swelling  Y  N  U  
 Other symptoms, signs, clinical findings, or complications consistent with this illness  Y  N  U  
 Please specify: \_\_\_\_\_

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

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**ISOLATION/QUARANTINE/CONTROL MEASURES**

Did local health director or designee implement additional control measures? .....  Y  N  U  
 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): \_\_\_\_/\_\_\_\_/\_\_\_\_

**TREATMENT**

Was botulism antitoxin given? .....  Y  N  U  
 Date antitoxin given (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Time treatment began \_\_\_\_\_  AM  PM  
 Did the patient require mechanical ventilation? .....  Y  N  U  
 If yes, give details: \_\_\_\_\_

**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 48 hours 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: \_\_\_\_\_

**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 48 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: from \_\_\_\_/\_\_\_\_/\_\_\_\_ until \_\_\_\_/\_\_\_\_/\_\_\_\_

During the 48 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 Department	<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	

During the 48 hours prior to onset of symptoms, did the patient use injection drugs not prescribed by a doctor? .....  Y  N  U  
 Specify drug(s): \_\_\_\_\_

During the 48 hours prior to onset of symptoms, did the patient use NON-injection street drugs? .....  Y  N  U

**OTHER EXPOSURE INFORMATION**

Does the patient know anyone else with similar symptoms? .....  Y  N  U  
 If yes, specify: \_\_\_\_\_

**FOOD RISK AND EXPOSURE**

Where does the patient/patient's family typically buy groceries?  
 Store name: \_\_\_\_\_  
 Store city: \_\_\_\_\_  
 Shopping center name/address: \_\_\_\_\_

During the 48 hours 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 48 hours prior to onset of symptoms, did the patient do any of the following:  
 Drink unpasteurized juices or ciders?  Y  N  U  
 Specify juices or ciders:  
 Apple  
 Orange  
 Other, specify: \_\_\_\_\_

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: \_\_\_\_\_

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)? .....  Y  N  U  
 Handle/eat clams? .....  Y  N  U  
 Handle/eat crabs? .....  Y  N  U  
 Handle/eat lobster? .....  Y  N  U  
 Handle/eat mussels? .....  Y  N  U  
 Handle/eat oysters? .....  Y  N  U  
 Handle/eat shrimp? .....  Y  N  U  
 Handle/eat crawfish? .....  Y  N  U  
 Handle/eat other shellfish? .....  Y  N  U

Handle/eat finfish (i.e. Tuna, Mackerel, Skip Jack, Amber Jack, Bonito, mahi-mahi / dorado, Blue fish, Salmon, Puffer fish, Porcupine fish, Ocean sunfish, sushi)? .....  Y  N  U  
 Specify type of finfish:  
 Tuna  Puffer fish  
 Mackerel  Parrot fish  
 Skip Jack or Amberjack  Porcupine fish  
 Bonito  Ocean sunfish (Mola mola)  
 Mahi-mahi  Bluefish  
 (dorado/"blue dolphin")  Salmon  
 Sushi, unknown type of fish  
 Other: specify \_\_\_\_\_  
 Unknown

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**FOOD RISK AND EXPOSURE (CONTINUED)**

**During the 48 hours prior to onset of symptoms, did the patient:**

**Handle/eat other seafood** (i.e. octopus, squid) or frogs?  Y  N  U  
Specify other seafood:  
 Squid  Octopus  Frog  
 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 \_\_\_\_\_

**Eat meat stews or meat pies?**  Y  N  U  
Specify: \_\_\_\_\_

**Eat gravy** (i.e. beef, chicken, turkey)?  Y  N  U  
Specify: \_\_\_\_\_

**Eat potentially hazardous foods** (i.e. pastries, custards, salad dressings)?  Y  N  U  
Specify:  
 Pastries  
 Custards  
 Salad dressings  
 Other: specify \_\_\_\_\_

**Eat commercially-prepared, refrigerated foods** (i.e. dips, salsa, sandwiches)?  Y  N  U  
Specify type of food:  
 Dips, specify: \_\_\_\_\_  
 Salsa  
 Sandwiches, Specify: \_\_\_\_\_  
 Other, Specify: \_\_\_\_\_

**Eat baked potatoes/sweet potatoes?**  Y  N  U

**Eat preserved, smoked, salted, fermented, or traditionally-prepared fish?**  Y  N  U

**Eat unviscerated** (entrails left in) **fish?**  Y  N  U

**Eat vacuum-packed** (modified atmosphere packing) **foods?**  Y  N  U

**Eat foods stored in oil?**  Y  N  U

**Eat foods that were processed/canned at home?**  Y  N  U

**Ingest/consume water or a drink made from water?**  Y  N  U

**Ingest breast milk?**  Y  N  U

**Ingest infant formula?**  Y  N  U

**Eat commercial baby food?**  Y  N  U

**Ingest honey** (i.e. via honey-filled pacifier, honey-water)?  Y  N  U

**Ingest molasses?**  Y  N  U

**Ingest corn syrup?**  Y  N  U

**Eat a known contaminated food product?**  Y  N  U  
Specify: \_\_\_\_\_

**Eat at a group meal?**  Y  N  U  
Specify:  
 Place of Worship  
 School:  
 Social function  
 Other, specify:  
Name: \_\_\_\_\_  
Location: \_\_\_\_\_

**Eat food from a restaurant?**  Y  N  U  
Name: \_\_\_\_\_  
Location: \_\_\_\_\_

**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

**Notes:**

## **Botulism, foodborne**

### **1996 CDC Case Definition**

#### **Clinical description**

Ingestion of botulinum toxin results in an illness of variable severity. Common symptoms are diplopia, blurred vision, and bulbar weakness. Symmetric paralysis may progress rapidly.

#### **Laboratory criteria for diagnosis**

- Detection of botulinum toxin in serum, stool, or patient's food, or
- Isolation of *Clostridium botulinum* from stool

#### **Case classification**

*Probable*: a clinically compatible case with an epidemiologic link (e.g., ingestion of a home-canned food within the previous 48 hours)

*Confirmed*: a clinically compatible case that is laboratory confirmed or that occurs among persons who ate the same food as persons who have laboratory-confirmed botulism