Botulism

West Virginia Electronic Disease Surveillance System

Division of Surveillance and Disease Control

Infectious Disease Epidemiology Program

Phone: 304-558-5358 or 800-423-1271 in West Virginia

Fax: 304-558-8736

Disease Under Investigation

* indicates required fields

Type

○ *Unspecified/Wound Unknown* ○ *Foodborne* ○ *Infant* ○ *Unspecified/Known not Wound* ○ *Wound*

Investigation Status*

○ *Closed* ○ *Open* ○ *Regional Review* ○ *State Review* ○ *Superceded* ○ *Unassigned*

Case Status*

○ *Confirmed* ○ *Not a Case* ○ *Probable* ○ *Suspect* ○ *Unknown*

Patient Information

* indicates required fields

Last Name*	**First Name***	**Middle Initial**

Street Address

City	**County**	**State**	**Zip**
		West Virginia	

Is the patient's residence a:

○ *Correctional Facility (Specify)*_____ ○ *Long Term Care Facility (Specify)*_____

○ *Shelter or Group Home (Specify)*_____ ○ *None of the above*

Home Phone ###-###-####	**Ext.**	**Other Phone** ###-###-####	**Ext.**	**Report Date** mm/dd/yyyy

Parent / Guardian Information

Last Name	**First Name**	**Middle Initial**	**Relationship to Patient**

○ *Check if address is same as above; otherwise complete guardian contact information below*

Guardian Street Address

City	**County**	**State**	**Zip**
		West Virginia	

Home Phone ###-###-####	**Ext.**	**Other Phone** ###-###-####	**Ext.**

Patient Demographic Information

* indicates required fields

Sex

○ *Male* ○ *Female* ○ *Transsexual* ○ *Unknown* ○ *Failure to report sex/missing sex* ○ *Other (Specify)*_____

Date of Birth* mm/dd/yyyy	**Age**	**Age Units**
		○ *Days* ○ *Weeks* ○ *Months* ○ *Years*

Patient Demographic Information cont.

Ethnicity

○ *Hispanic or Latino* ○ *Not Hispanic or Latino* ○ *Unknown* ○ *Failure to report ethnicity/missing ethnicity*

Race

(Check all that apply)

☐ *American Indian or Alaska Native* ☐ *Asian*
☐ *Black or African American* ☐ *Native Hawaiian or Other Pacific Islander*_____
☐ *White* ☐ *Unknown*
☐ *Failure to report race/missing race* ☐ *Some Other Race*_____

Outcome and Clinical Information

Date of onset of symptoms mm/dd/yyyy	**Date of diagnosis** mm/dd/yyyy

Was the patient hospitalized for the disease? ○ *Yes* ○ *No* ○ *Unknown*	**Name of Hospital**	**Date of Admission** mm/dd/yyyy

Patient outcome from this disease: ○ *Died* ○ *Survived* ○ *Unknown*	**Date of Death** mm/dd/yyyy

Clinical Data

Recent medication history:	**Phenothiazine** ○ *Yes* ○ *No*	**Aminoglycoside** ○ *Yes* ○ *No*	**Anticholinergic** ○ *Yes* ○ *No*	**Other, specify**

Abdominal Pain ○ *Yes* ○ *No* ○ *Unknown*	**Nausea** ○ *Yes* ○ *No* ○ *Unknown*	**Vomiting** ○ *Yes* ○ *No* ○ *Unknown*	**Diarrhea** ○ *Yes* ○ *No* ○ *Unknown*
Blurred vision ○ *Yes* ○ *No* ○ *Unknown*	**Diplopia (double vision)** ○ *Yes* ○ *No* ○ *Unknown*	**Dizziness** ○ *Yes* ○ *No* ○ *Unknown*	**Slurred speech** ○ *Yes* ○ *No* ○ *Unknown*
Sensation of "thick tongue" ○ *Yes* ○ *No* ○ *Unknown*	**Hoarseness** ○ *Yes* ○ *No* ○ *Unknown*	**Dry Mouth** ○ *Yes* ○ *No* ○ *Unknown*	**Difficulty swallowing** ○ *Yes* ○ *No* ○ *Unknown*
Shortness of breath ○ *Yes* ○ *No* ○ *Unknown*	**Subjective weakness** ○ *Yes* ○ *No* ○ *Unknown*	**Fatigue** ○ *Yes* ○ *No* ○ *Unknown*	**Parasthesia** ○ *Yes* ○ *No* ○ *Unknown*

If yes, describe

Vital Signs:

Temperature	**Blood Pressure** ____/____	**Heart Rate** _____/ min	**Respiratory Rate** _____/ min

Altered mental state ○ *Yes* ○ *No* ○ *Unknown*	**Extra-ocular palsy** ○ *Yes* ○ *No* ○ *Unknown*	**Ptosis** ○ *Yes* ○ *No* ○ *Unknown*	**Pupils dilated** ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*
Pupils constricted ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*	**Pupils fixed** ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*	**Pupils reactive** ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*	
Facial paralysis ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*	**Palatal weakness** ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*	**Impaired gag reflex** ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*	
Wound ○ *Yes, describe* ○ *No* ○ *Unknown*	**Sensory deficits** ○ *Yes, describe* ○ *No* ○ *Unknown*	**Abnormal deep tendon reflexes** ○ *Yes, describe* ○ *No* ○ *Unknown*	

Weakness/Paralysis

Indicate if weakness or paralysis was noted before antitoxin release

Extremities:

Upper distal ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*	**Upper proximal** ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*	**Lower distal** ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*
Lower proximal ○ *Yes* ○ *No* ○ *Unknown* ○ *Bilateral*	**Describe progression of the weakness/paralysis** ○ *Ascending* ○ *Descending* ○ *Unknown*	

Outcome and Clinical Information cont.

Morbidity:

List morbidity present before toxin release:

Admitted to intensive care
○ *Yes* ○ *No* ○ *Unknown*

Intubated
○ *Yes* ○ *No* ○ *Unknown*

Tracheostomy
○ *Yes* ○ *No* ○ *Unknown*

Other
○ *Yes* ○ *No* ○ *Unknown*

Describe general symptom progression, if not already covered:

Laboratory Data

Lumbar puncture
○ *Not done* ○ *Done*

If Done, Date
mm/dd/yyyy

RBC

WBC

Differential

Segs/Polys

Lymphs

Monocytes

Other

Protein

Glucose

Laboratory Name

Phone
###-###-####

Ext.

Fax Number
###-###-####

Address

State:
West Virginia

Zip:

Tensilon test
○ *Not done* ○ *Done*

If done, date
mm/dd/yyyy

Electromyelography (EMG)
○ *Not done* ○ *Done*

If done, date
MM/DD/YY

Muscle group
○ *Not done* ○ *Done*

Nerve conduction studies
○ *Not done* ○ *Done*

Rapid repetitive stimulation
○ *Not done* ○ *Done*

Stimulated at
_____ Hz

Forced vital capacity
○ *Not done* ○ *Done*

If done, date
MM/DD/YY

Results
_____ liters

Serum for toxin

Date
mm/dd/yyyy

Results

Stool for toxin

Date
mm/dd/yyyy

Results

Stool Culture

Date
mm/dd/yyyy

Results

Food

Food

Date
mm/dd/yyyy

Results

Other

Other

Date
mm/dd/yyyy

Results

Reporting Source

Last Name	**First Name**	
Phone ###-###-####	**Ext.**	**Fax** ###-###-####
Facility		
Address		
City	**State** West Virginia	**Zip**
E-mail		

Provider with Further Patient Information

Last Name	**First Name**	
Phone ###-###-####	**Ext.**	**Fax** ###-###-####
Address		
City	**State** West Virginia	**Zip**

Summary of Follow-up and Comments

Follow-up and Comments
(Check all that apply)

☐ *Referral to physician* ☐ *Follow up of others who ate suspect food* ☐ *Referral of suspect food to regulatory agency*
☐ *Restaurant inspection* ☐ *Education on proper canning technique provided* ☐ *Other*_____

Public Health Investigation

Name of Person Interviewed	**Relationship to Patient**	**Date reported to public health** mm/dd/yyyy

Investigator	**Date public health investigation began** mm/dd/yyyy	**Health Department**	**Phone** ###-###-####
Ext.			

Investigation ID	**Part of an Outbreak?**	**Outbreak Name**	**Lost to follow-up?**
	○ *Yes* ○ *No* ○ *Unknown*		○ *Yes* ○ *No*

Public Health Investigation cont.

Notes on Botulinum Antitoxin:

Physician contact	**Phone** ###-###-####	**Pharmaceutical contact**	**Phone** ###-###-####

Hospital

Antitoxin released?	**Antitoxin administered?**	**If yes, date** mm/dd/yyyy	**Time**	**IDEP Epidemiologist**
○ *Yes* ○ *No*	○ *Yes* ○ *No*			

CDC contact

Details of antitoxin shipping

Possible Sources of Exposure

Skip this section if case is already epi-linked. Note - If no obvious source is identified or two or more cases are identified, an 8-day food and activity history is indicated. Consult IDEP.

For Foodborne Botulism

Home-canned food	**Sausage or other preserved meats**	**Preserved fish**	**Items stored in oil (spice flavored oils); e.g., onions, garlic, mushrooms**
○ *Yes* ○ *No*	○ *Yes* ○ *No*	○ *Yes* ○ *No*	○ *Yes* ○ *No*

Baked potato stored in foil	**Items held at room temperature/refrigerated or heated improperly**	**Other**
○ *Yes* ○ *No*	○ *Yes* ○ *No*	○ *Yes* ○ *No*

For Wound Botulism

Injection drug use	**Black tar heroin use**	**Other**
○ *Yes* ○ *No*	○ *Yes* ○ *No*	○ *Yes* ○ *No*

For Infant Botulism

Honey

○ *Yes* ○ *No*

Activity History

List all group activities, parties or gatherings (wedding receptions, baby showers, church events, school events, athletic events, office parties or banquets, festivals, or fairs) attended in the last 2 hours to 8 days prior to onset.

Date	Activity	Location
MM/DD/YY		

Contact Management & Follow-Up

Does the case know about anyone else with a similar illness?

○ *Yes* ○ *No* ○ *Could not be interviewed*

If Yes, provide names, age, onset date, contact information, and relationship to case below:

Name	Age	Onset Date	Phone Number	Address	Relationship to Case
		MM/DD/YY	###-###-####		

Food Purchased

Date	Name	Location	Food Purchased
MM/DD/YY			

8 Day Food History

Day 1

Date mm/dd/yyyy

Meal	Food/Beverage Consumed	Location
Breakfast		
Dinner		
Lunch		
Snacks		

8 Day Food History cont.

Day 2		**Date** mm/dd/yyyy
Meal	**Food/Beverage Consumed**	**Location**
Breakfast		
Dinner		
Lunch		
Snacks		

Day 3		**Date** mm/dd/yyyy
Meal	**Food/Beverage Consumed**	**Location**
Breakfast		
Dinner		
Lunch		
Snacks		

Day 4		**Date** mm/dd/yyyy
Meal	**Food/Beverage Consumed**	**Location**
Breakfast		
Dinner		
Lunch		
Snacks		

Day 5		**Date** mm/dd/yyyy
Meal	**Food/Beverage Consumed**	**Location**
Breakfast		
Dinner		
Lunch		
Snacks		

Day 6		**Date** mm/dd/yyyy
Meal	**Food/Beverage Consumed**	**Location**
Breakfast		
Dinner		
Lunch		
Snacks		

8 Day Food History cont.

Day 7	**Date** mm/dd/yyyy

Meal	Food/Beverage Consumed	Location
Breakfast		
Dinner		
Lunch		
Snacks		

Day 8	**Date** mm/dd/yyyy

Meal	Food/Beverage Consumed	Location
Breakfast		
Dinner		
Lunch		
Snacks		

Public Health Action Taken

Describe public health action taken