



Typhoid Fever

County _____

LHJ Use ID _____
 Reported to DOH Date ___/___/___
 LHJ Classification Confirmed
 Probable
 By: Lab Clinical
 Epi Link: _____

Outbreak-related

LHJ Cluster# _____

LHJ Cluster Name: _____

DOH Outbreak # _____

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___

Reporter (check all that apply) Lab Hospital HCP
 Public health agency Other

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

OK to talk to case? Yes No DK Date of interview ___/___/___

PATIENT INFORMATION

Name (last, first) _____

Address _____ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact Parent/guardian Spouse Other Name: _____

Zip code (school or occupation): _____ Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ___/___/___ Age _____

Gender F M Other Unk

Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk

Race (check all that apply)

Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk

CLINICAL INFORMATION

Onset date: ___/___/___ Derived Diagnosis date: ___/___/___ Illness duration: ___ days

Signs and Symptoms

Y N DK NA

Diarrhea Maximum # of stools in 24 hours: _____

Constipation

Abdominal cramps or pain

Loss of appetite (anorexia)

Fever Highest measured temp (°F): _____
 Oral Rectal Other: _____ Unk

Night sweats

Headache

Malaise

Cough Onset date: _____

Nonproductive cough

Predisposing Conditions

Y N DK NA

Previously known typhoid carrier

Immunosuppressive therapy or disease

Underlying illness Specify: _____

Clinical Findings

Y N DK NA

Rash - rose spots

Splenomegaly

Hospitalization

Y N DK NA

Hospitalized at least overnight for this illness

Hospital name _____

Admit date ___/___/___ Discharge date ___/___/___ Exception _____

Y N DK NA

Died from illness Death date ___/___/___

Autopsy Place of death _____

Vaccination

Y N DK NA

Typhoid vaccine in past 5 years

Date of last vaccination (mm/yyyy): ___/___/___

Typhoid vaccine type: _____

Laboratory

Collection date ___/___/___

Source _____

P = Positive O = Other
 N = Negative NT = Not Tested
 I = Indeterminate

P N I O NT

S. typhi culture (clinical specimen)

NOTES

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Days from onset:	Exposure period		o n s e t	Contagious period
	-60	-3		weeks
Calendar dates:				

EXPOSURE (Refer to dates above)

<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Travel out of the state, out of the country, or outside of usual routine Out of: <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Country Dates/Locations: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Case knows anyone with similar symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Epidemiologic link to a confirmed human case</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with lab confirmed case <input type="checkbox"/> Casual contact <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Needle use <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with known typhoid carrier Nature of contact: <input type="checkbox"/> Casual contact <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Needle use <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with diapered or incontinent child or adult</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Refrigerated, prepared food (e.g. dips, salsas, salads, sandwiches)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Unpasteurized milk (cow)</p>	<p>Y N DK NA</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Known contaminated food product</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Group meal (e.g. potluck, reception)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Food from restaurants Restaurant name/Location: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Source of drinking water known <input type="checkbox"/> Individual well <input type="checkbox"/> Shared well <input type="checkbox"/> Public water system <input type="checkbox"/> Bottled water <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Drank untreated/unchlorinated water (e.g. surface, well)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Employed in laboratory</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Contact with recent foreign arrival Nature of contact: <input type="checkbox"/> Casual <input type="checkbox"/> Household <input type="checkbox"/> Sexual <input type="checkbox"/> Needle use <input type="checkbox"/> Other: _____ Specify country: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foreign arrival (e.g. immigrant, refugee, adoptee, visitor) Specify country: _____</p>
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Where did exposure probably occur? In WA (County: _____) US but not WA Not in US Unk

Exposure details: _____

- No risk factors or exposures could be identified
- Patient could not be interviewed

PATIENT PROPHYLAXIS/TREATMENT

PUBLIC HEALTH ISSUES

Y N DK NA

Employed as food worker

Non-occupational food handling (e.g. potlucks, receptions) during contagious period

Employed in child care or preschool

Attends child care or preschool

Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset Date: ___/___/___
 Agency and location: _____
 Type of donation: _____

PUBLIC HEALTH ACTIONS

Exclude individuals from sensitive occupation (HCW, child care) or situation (child care) until 3 negative stools

Consider excluding symptomatic contacts from sensitive occupations (HCW, food, child care) or situations (child care) until 2 negative stools

Notify others sharing exposure

Hygiene education provided

Child care inspection

Follow-up of household members

Work or child care restriction for household member

Notify blood or tissue bank

Other, specify: _____

NOTES

Investigator _____ Phone/email: _____	Investigation complete date ___/___/___
Local health jurisdiction _____	Record complete date ___/___/___