



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 ____/____/____
 Reporter (check all that apply)
 Lab Hospital HCP
 Public health agency Other
 OK to talk to case? Yes No Don't know

Investigation start date: ____/____/____

Reporter name _____
 Reporter phone _____
 Primary HCP name _____
 Primary HCP phone _____

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
 Race (check all that apply)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other

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 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 ___ / ___ / ___