



**Immediately notify
DOH Communicable
Disease Epidemiology
Phone: 877-539-4344**

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 # _____

Botulism, wound

County _____

REPORT SOURCE

LHJ notification date ___/___/___ Investigation start date ___/___/___ Reporter name _____
 Reporter (check all that apply) Lab Hospital HCP Reporter phone _____
 Public health agency Other Primary HCP name _____
 OK to talk to case? Yes No DK Date of interview ___/___/___ Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____ Birth date ___/___/___ Age _____
 Address _____ Homeless Gender F M Other Unk
 City/State/Zip _____ Ethnicity Hispanic or Latino
 Not Hispanic or Latino Unk
 Phone(s)/Email _____ Race (check all that apply)
 Alt. contact Parent/guardian Spouse Other Name: _____
 Amer Ind/AK Native Asian
 Zip code (school or occupation): _____ Phone: _____
 Native HI/other PI Black/Afr Amer
 Occupation/grade _____ White Other Unk
 Employer/worksite _____ School/child care name _____

CLINICAL INFORMATION

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

Signs and Symptoms

Y N DK NA
 Swallowing or speech difficulty
 Eyelids drooping (ptosis)
 Vision blurred or double
 Breathing difficulty or shortness of breath
 Diarrhea Maximum # of stools in 24 hours: _____
 Constipation

Predisposing Conditions

Y N DK NA
 Contaminated wound during the 2 weeks before onset of symptoms
 Gastric surgery or gastrectomy in past

Clinical Findings

Y N DK NA
 Cranial nerve abnormalities (bulbar weakness)
 Respiratory distress
 Paralysis or weakness
 Acute flaccid paralysis Asymmetric
 Symmetric Ascending Descending
 Abscess or infected lesion
 Mechanical ventilation or intubation required during hospitalization
 Admitted to intensive care unit

Hospitalization

Y N DK NA
 Hospitalized at least overnight for this illness

Hospital name _____
 Admit date ___/___/___ Discharge date ___/___/___

Y N DK NA
 Died from illness Death date ___/___/___
 Autopsy Place of death _____

Laboratory

Collection date ___/___/___
 Source _____

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

P N I O NT

Botulinum toxin (serum)
 C. botulinum culture (wound)

Toxin type: A B C D E
 F G Unknown

NOTES

INFECTION TIMELINE

Enter onset date/time (first sx) in heavy box. Count backward to determine probable exposure period

Exposure period

Hours from onset: - 168 -12

Calendar date/time:

EXPOSURE (Refer to dates above)

Y N DK NA

Travel out of the state, out of the country, or outside of usual routine
 Out of: County State Country
 Dates/Locations: _____

Y N DK NA

Does the case know anyone else with similar symptoms or illness

Contact with lab confirmed case
 Nature of contact:
 Household Casual Sexual
 Needle use Other: _____

Epidemiologic link (e.g. ingestion of same food eaten by person with lab-confirmed botulism)

Epidemiologic link (e.g. ingestion of a home-canned food within the previous 48 hours)

Home canned food

Y N DK NA

Dried, preserved, or traditionally prepared meat (e.g. sausage, salami, jerky)

Preserved, smoked, or traditionally prepared fish

Vacuum packed (modified atmosphere packaging) foods

Foods stored in oil (e.g. garlic, sun dried tomatoes)

Group meal (e.g. potluck, reception)

Food from restaurants
 Restaurant name/Location: _____

Suspected exposure to botulism contaminated food

Known contaminated food product
 Specify: _____

Non-injection street drug use

Injection street drug use within 2 weeks of onset
 Injection street drug use type: _____

Source of botulism exposure identified
 Specify: _____

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 AND TREATMENT

Y N DK NA

Antibiotics taken for this illness Name: _____
 Date/time antibiotic treatment began: ___/___/___ AM PM # days antibiotic actually taken: _____

Botulism antitoxin given Date/time given: ___/___/___ AM / PM

PUBLIC HEALTH ISSUES

PUBLIC HEALTH ACTIONS

Initiate traceback investigation

Notify others potentially exposed
 Date initiated: ___/___/___

Referral to physician

Other, specify: _____

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ___/___/___

Local health jurisdiction _____ Record complete date ___/___/___