



**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, infant

County _____

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) _____ 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)
 Amer Ind/AK Native Asian
 Native HI/other PI Black/Afr Amer
 White Other Unk
 Alt. contact Parent/guardian Spouse Other Name: _____
 Zip code (school or occupation): _____ Phone: _____
 Occupation/grade _____
 Employer/worksite _____ School/child care name _____

CLINICAL INFORMATION

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

Signs and Symptoms

- Y N DK NA
 Poor feeding
 Constipation
 Weakness
 Head drooping
 Eyelids drooping (ptosis)
 Cry weak or altered
 Breathing difficulty or shortness of breath
 Diarrhea Maximum # of stools in 24 hours: _____

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 _____

Predisposing Conditions

- Y N DK NA
 Preexisting injury, wound, or break in skin
 Gastric surgery or gastrectomy in past

Laboratory

Collection date ____/____/____
 Source _____
 P N I O NT
 Botulinum toxin detection (serum or stool)
 Serum Stool
 C. botulinum isolation (stool)
 Food specimen submitted for testing
 Toxin type: A B C D E
 F G Unknown

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

Clinical Findings

- Y N DK NA
 Floppy or weak baby
 Failure to thrive
 Respiratory distress
 Paralysis or weakness
 Acute flaccid paralysis Asymmetric
 Symmetric Ascending Descending
 Mechanical ventilation or intubation required during hospitalization
 Admitted to intensive care unit

NOTES

INFECTION TIMELINE

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

Hours from onset: - 168 -12

o
n
s
e
t

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: _____

If infant, breast fed
 Infant formula
 Commercial baby food

Y N DK NA

Honey (e.g. honey-filled pacifier, honey water)
 Corn syrup
 Home canned food
 Dried, preserved, or traditionally prepared meat (e.g. sausage, salami, jerky)
 Preserved, smoked, or traditionally prepared fish
 Known contaminated food product
 Specify: _____
 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

Botulism antiserum given Y N DK NA Date/time given: ___/___/___ _____ AM / PM

PUBLIC HEALTH ISSUES

NOTES

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