



**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 # _____

Shellfish Poisoning: Paralytic, Domoic Acid

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
- Mouth tingling or numbness
 - Breathing difficulty or shortness of breath
 - Weakness
 - Memory loss
 - Extremities numb
 - Swallowing or speech difficulty
 - Eyelids drooping (ptosis)
 - Vision blurred or double
 - Vomiting
 - Diarrhea Maximum # of stools in 24 hours: _____

Clinical Findings

- Y N DK NA
- Ataxia
 - Cranial nerve abnormalities (bulbar weakness)
 - Paralysis or weakness
 - Acute paralysis Dysphagia
 - Dysphonia Cranial nerves
 - Excessive respiratory secretions
 - Respiratory failure
 - Cardiac arrhythmia
 - Memory impairment
 - Confusion
 - Seizures
 - Coma
 - Admitted to intensive care unit
 - Mechanical ventilation or intubation required during hospitalization

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

- High levels of associated dinoflagellates in source water for epidemiologically implicated shellfish
- Saxitoxin in epidemiologically implicated food
- Domoic acid in epidemiologically implicated food

NOTES

