### Typhoid Fever Case Report Form

**ADMINISTRATIVE**
- **Investigator** __________________________
- **LHJ Case ID (optional)** __________________________
- **LHJ notification date __/__/____

**DEMOGRAPHICS**
- **Age at symptom onset __/__/____ Years Months**
- **Ethnicity**
  - Hispanic or Latino
  - Not Hispanic or Latino
  - Unk
- **Race**
  - (check all that apply)
  - Unk
  - Amer Ind/AK Native
  - Asian
  - Black/African Amer
  - Native HI/other PI
  - White
  - Other

**Typhoid Fever**
- **County** ______________________________________
- **Address type**
  - Home
  - Mailing
  - Other
  - Temporary
  - Work
- **Street address** ______________________________________
- **City/State/Zip/County** __________________________
- **Residence type (incl. Homeless)** __________________________
- **WA resident**
  - Yes
  - No

**REPORT SOURCE**
- **Initial report source** __________________________
  - LHJ
  - Reporter organization __________________________
  - Reporter name __________________________
  - Reporter phone __________________________

**COMMUNICATIONS**
- **Primary HCP name** __________________________
- **Phone** __________________________
- **OK to talk to patient (If Later, provide date)**
  - Yes
  - Later __/__/____
  - Never
- **Date of interview attempt __/__/____**
  - Complete
  - Partial
  - Unable to reach
  - Patient could not be interviewed
- **Alternate contact**
  - Parent/Guardian
  - Spouse/Partner
  - Friend
  - Other

**CLINICAL INFORMATION**
- **Complainant ill**
  - Yes
  - No
  - Unk
- **Symptom Onset __/__/____**
- **Illness duration ____ Days ____ Weeks ____ Months ____ Years**
- **Illness is still ongoing**
  - Yes
  - No
  - Unk

**Signs and Symptoms**
- **Any fever, subjective or measured**
  - If yes, Temp measured?
  - Yes
  - No
  - Highest measured temp _______°F
- **Constipation**
- **Abdominal pain or cramps**
- **Anorexia (loss of appetite)**
- **Night sweats**
- **Headache**
- **Malaise**
- **Cough**
  - Onset date __/__/____
- **Nonproductive cough**
- **Diarrhea (3 or more loose stools within a 24 hour period)**
  - Onset date __/__/____
- **Fatigue**

---

**Typhoid Fever case required are in bold. Answers are: Yes, Maybe, No, Unknown to case**

DOH 210-050(Rev. 11/2019)
**Clinical Findings**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rash-rose spots</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Relative bradycardia (heart rate that, although not actually below 60 BPM, is still considered too slow for the individual’s current medical condition)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Splenomegaly</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Predisposing Illness**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovered</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Died</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Unknown</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Clinical Findings**

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<td>No</td>
</tr>
<tr>
<td>Unknown</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Predisposing Conditions**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previously known typhoid carrier</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Immunosuppressive therapy or condition, or disease</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other underlying medical condition</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Vaccination**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typhoid vaccine within 5 years before illness onset</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Hospitalization**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalized at least overnight for this illness</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hospital admission date</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Discharge</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Facility name</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Admitted to ICU</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Date admitted to ICU</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Date discharged from ICU</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mechanical ventilation or intubation required</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Still hospitalized</td>
<td>Yes</td>
<td>No</td>
</tr>
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</table>

**Outcome of illness**

<table>
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<tr>
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<th>N</th>
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<td>No</td>
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<tr>
<td>Unknown</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**RISK AND RESPONSE**

**Travel**

<table>
<thead>
<tr>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel out of:</td>
<td>County/City</td>
<td>County/City</td>
</tr>
<tr>
<td></td>
<td>State</td>
<td>State</td>
</tr>
<tr>
<td></td>
<td>Country</td>
<td>Country</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>Destination name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start and end dates</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Risk and Exposure Information**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Contact with lab confirmed case</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Childcare/Day care</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Household</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sexual</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Needle use</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Contact with known Typhoid carrier</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Date(s) of contact</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Was the carrier previously known to the health department</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Day care</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Household</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Sexual</td>
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<td>No</td>
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<td>Needle use</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Other</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Contact with recent foreign arrival</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Country</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Date(s) of contact</td>
<td>Yes</td>
<td>No</td>
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**Typhoid Fever required variables are in bold. Answers are: Yes, Maybe, No, Unknown to case**
Cases Name ___________________________________ LHJ Case ID ___________________________________

Typhoid Fever required variables are in **bold**. Answers are: Yes, Maybe, No, Unknown to case

Day care  Household  Sexual  Needle use  Other ______________________

Does the case know anyone else with similar symptoms or illness
Onset date, shared meals, relationship, etc. ______________________________

Attends child-care or preschool  Location/details ____________________________

Contact with diapered or incontinent child or adult __________________________

**Food Exposure - Food exposure timeframe: 3-60 days prior to onset of illness**

**Sources of food IN home** - During exposure timeframe did you (your child) eat foods from:

- [ ] (1) Grocery stores or supermarkets
- [ ] (2) Home delivery grocery services (CSA, grocery delivery, Amazon Fresh, Peapod, etc)
- [ ] (3) Fish or meat specialty shops (butcher shop, etc)
- [ ] (4) Warehouse stores (Costco, Sam’s Club, etc.)
- [ ] (5) Meal delivery services (Blue Apron, Meals on Wheels, Schwan’s, NutriSystem, etc)
- [ ] (6) Live animal market, custom slaughter facility

**Sources of food outside home** - During exposure timeframe did you (your child) eat foods from:

- [ ] (1) Fast casual (Chipotle, Panera, etc)
- [ ] (2) Fast food (McDonald’s, Burger King, Wendy’s)
- [ ] (3) Sandwich shop, deli
- [ ] (4) Jamaican, Cuban, or Caribbean
- [ ] (5) Ready-to-eat prepared food from grocery or deli
- [ ] (6) An event where food was served (catered event, festival, church, or community meal)
- [ ] (7) Mexican, Salvadorian, other Hispanic/Latino-style
- [ ] (8) Food trucks, food stalls/stands
- [ ] (9) School, hospital, senior center, or other institutional setting
- [ ] (10) Chinese, Japanese, Vietnamese, other Asian-style
- [ ] (11) All-you-can-eat buffet
- [ ] (12) Breakfast, brunch, dîner, or café
- [ ] (13) Middle Eastern, Greek/Mediterranean, Arabic, Lebanese, African
- [ ] (14) Any takeout from a restaurant
- [ ] (15) Healthy restaurant (vegetarian, vegan, salad-based)
- [ ] (16) Salad bar at a grocery store or restaurant
- [ ] (17) Other ______________________________

<table>
<thead>
<tr>
<th>Type of Business (enter number next to choices above)</th>
<th>Business name</th>
<th>Address/location</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Type of Business (enter number next to choices above)</th>
<th>Restaurant/venue name</th>
<th>Date</th>
<th>Time of meal (Breakfast, Brunch, Lunch, Happy Hour, Dinner, Other)</th>
<th>Food ordered/eaten</th>
<th>Address/location</th>
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Typhoid Fever required variables are in **bold**. Answers are: Yes, Maybe, No, Unknown to case
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---

**Case Name** ___________________________________  
**LHJ Case ID** ___________________________________  

---

**Typhoid Fever required variables are in bold.**  
**Answers are:** Yes, Maybe, No, Unknown to case  

---

### Bfast  
**Bru**  
**Lun**  
**HH**  
**Din**  
**Other** ___________  

---

### Other ___________  

---

**Y M N Unk**  
☐ ☐ ☐ ☐ Any food sampled (grocery, warehouse stores, food court, etc.) __________________________________________  

---

**Y M N Unk**  
☐ ☐ ☐ Refrigerated, prepared food (e.g., dips, salsas, salads, sandwiches)  

---

**Water Exposure**  
**Y N Unk**  
☐ ☐ ☐ ☐ Source of drinking water known  
☐ ☐ ☐ Bottled water ____________________________  

---

**Y N Unk**  
☐ ☐ ☐ Public water system ____________________________  
☐ ☐ ☐ Individual well ____________________________  
☐ ☐ ☐ Shared well ____________________________  
☐ ☐ ☐ Other ____________________________  
☐ ☐ ☐ Untreated/unchlorinated water (e.g., surface, well, lake, stream, spring) ____________________________  

---

### Exposure and Transmission Summary  
**Y N Unk**  
☐ ☐ ☐ Epi-linked to a confirmed case  
☐ ☐ ☐ Known contaminated food product Specify ____________________________  
☐ ☐ ☐ Outbreak related ____________________________  

---

**Likely geographic region of exposure**  
☐ ☐ ☐ In Washington – county _____________  
☐ ☐ ☐ Other state _____________  
☐ ☐ ☐ Not in US - country _____________  
☐ ☐ ☐ Unk ____________________________  

---

**International travel related**  
☐ ☐ ☐ During entire exposure period  
☐ ☐ ☐ During part of exposure period  
☐ ☐ ☐ No international travel  

---

**Suspected exposure type**  
☐ ☐ ☐ Foodborne  
☐ ☐ ☐ Waterborne  
☐ ☐ ☐ Person to person  
☐ ☐ ☐ Sexual  
☐ ☐ ☐ Blood products  
☐ ☐ ☐ IDU  
☐ ☐ ☐ Unknown  
☐ ☐ ☐ Other ____________________________  

---

Exposure summary ____________________________  

---

**Public Health Issues**  
**Y N Unk**  
☐ ☐ ☐ Employed as a food handler  
☐ ☐ ☐ Non-occupational food handling (e.g., potlucks, receptions) during contagious period  
☐ ☐ ☐ Employed in childcare or preschool  
☐ ☐ ☐ Attends childcare or preschool  
☐ ☐ ☐ Did case donate blood products, organs or tissue (including ova or semen) in the 30 days before symptom onset or diagnosis Date / /  

Agency/location ____________________________ Type of donation ____________________________  

---

*If needed, enter detailed information in the Transmission Tracking Question Package*  

---

**Public Health Interventions/Actions**  
**Y N Unk**  
☐ ☐ ☐ Exclude individuals in a sensitive occupation (HCW, childcare) or situation (childcare) until 3 negative stools  
Case cleared ☐ ☐ 3 negative labs ☐ ☐ Health Officer approved ☐ ☐ Other  
☐ ☐ ☐ Consider excluding symptomatic contacts from sensitive occupations (HCW, food, childcare) or situations (childcare) until 2 negative stools  
☐ ☐ ☐ Notify others sharing exposure  
☐ ☐ ☐ Notified blood or tissue bank (if recent donation)  
☐ ☐ ☐ Hygiene education provided  
☐ ☐ ☐ Childcare inspection  
☐ ☐ ☐ Follow-up of household members  
☐ ☐ ☐ Work or childcare restriction for household member  
☐ ☐ ☐ Letter sent Date / /  
Batch date / /  
☐ ☐ ☐ Any other public health action  

---

Typhoid Fever required variables are in **bold**. Answers are: Yes, Maybe, No, Unknown to case  

---

Page 4
**TRANSMISSION TRACKING**

Visited, attended, employed, or volunteered at any public settings while contagious □ Yes □ No □ Unk

Settings and details (check all that apply)
- Day care
- School
- Airport
- Hotel/Motel/Hostel
- Transit
- Health care
- Home
- Work
- College
- Military
- Correctional facility
- Place of worship
- International travel
- Out of state travel
- LTCF
- Homeless/shelter
- Social event
- Large public gathering
- Restaurant
- Other

<table>
<thead>
<tr>
<th>Setting Type (as checked above)</th>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
<th>Setting 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start Date</td>
<td></td>
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<tr>
<td>End Date</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Time of Arrival</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time of Departure</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of people potentially exposed</th>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
<th>Setting 4</th>
</tr>
</thead>
</table>

Details (hotel room #, HC type, transit info, etc.)

<table>
<thead>
<tr>
<th>Contact information available for setting (who will manage exposures or disease control for setting)</th>
<th>Setting 1</th>
<th>Setting 2</th>
<th>Setting 3</th>
<th>Setting 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Y □ N □ Unk</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Is a list of contacts known?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Y □ N □ Unk</td>
<td></td>
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</tr>
</tbody>
</table>

If list of contacts is known, please fill out Contact Tracing Form Question Package

**TREATMENT**

□ □ □ Did patient receive prophylaxis/treatment

Specify medication ____________________________

**NOTES**
### LAB RESULTS

**Lab report information**
- **Lab report reviewed – LHJ**: □
- WDRS user-entered lab report note

**Submitter**

**Performing lab for entire report**

**Referring lab**

### Specimen

**Specimen identifier/accession number**

**Specimen collection date** ___/___/___  **Specimen received date** ___/___/___

**WDRS specimen type**

**WDRS specimen source site**

**WDRS specimen reject reason**

### Test performed and result

**WDRS test performed**

**WDRS test result, coded**

**WDRS test result, comparator**

**WDRS result, numeric only** (enter only if given, including as necessary Comparator and Unit of measure)

**WDRS unit of measure**

**Test method**

**WDRS interpretation code**

**Test result – Other, specify**

**WDRS result summary**
- □ Positive
- □ Negative
- □ Indeterminate
- □ Equivocal
- □ Test not performed
- □ Pending

**Test result status**
- □ Final results: Can only be changed with a corrected result
- □ Preliminary results
- □ Record coming over is a correction and thus replaces a final result
- □ Results cannot be obtained for this observation
- □ Specimen in lab; results pending

**Result date** ___/___/___

### Upload document

**Ordering Provider**

**WDRS ordering provider**

**Ordering facility**

**WDRS ordering facility name**

---

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