

## TYPHOID FEVER CASE INVESTIGATION FORM

*Use this form to interview confirmed and probable cases of typhoid and paratyphoid fever. That is Salmonella with serotypes Typhi, Paratyphi A, B, or C. Paratyphi B var. L(+)-tartate+ (Formerly Java) is a different serotype and should be handled as routine salmonellosis*

*Please FAX completed forms to CDPHE.*

**Questions marked with \* are required in FoodNet counties (Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson) and must be entered into CEDRS**

Patient Name: _____	CEDRS # _____	Interview date: ___/___/___
Agency Name: _____		Form Completed by: _____
Person interviewed: Case    Other (circle: Parent    Spouse    Household member    Friend )		

**Demographics and Contact Information**

\*Date of Birth \_\_\_/\_\_\_/\_\_\_      Age: \_\_\_\_\_ (Circle: Yrs., Mos., Days)      \*Sex: F    M

\*Race (Circle all that apply):

American Indian/Alaska Native	Asian	Black	Unknown
Pacific Islander/Hawaiian Native	White	Other	

\*Ethnicity (circle one):    Hispanic      Non Hispanic      Unk

Citizenship:    USA    Other: \_\_\_\_\_    Unk

Language spoken: \_\_\_\_\_      Parent/legal guardian: \_\_\_\_\_

Residence:

Address: \_\_\_\_\_  
 City: \_\_\_\_\_  
 County: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_

Phone Numbers:

Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Work Phone: (\_\_\_\_) \_\_\_\_\_  
 Pager: (\_\_\_\_) \_\_\_\_\_  
 Mobile: (\_\_\_\_) \_\_\_\_\_

**Laboratory information**

**\*\*\*please confirm all lab information with patient\*\*\***

Culture confirmed:	Yes	No	<b>Serotype:</b>	Typhi	Paratyphi A	Paratyphi B	Paratyphi C
<i>If yes, lab or hospital name: _____</i>							
*Date specimen(s) collected:	___/___/___			*Specimen source:	Stool	Gall bladder	
					Blood	Other: _____	
Was antibiotic sensitivity testing performed on this isolate at the clinical laboratory?				Yes	No	Unk	
<i>If yes, was the organism <b>resistant</b> to:</i>				<i>(Call the clinical lab for this information)</i>			
	Ampicillin	Yes	No	Not tested			
	Chloramphenicol	Yes	No	Not tested			
	Trimethoprim-sulfamethoxazole (Bactrim)	Yes	No	Not tested			
	Fluoroquinolones (e.g. Cipro)	Yes	No	Not tested			

Physician Name: \_\_\_\_\_      MD Phone: (\_\_\_\_) \_\_\_\_\_  
 Clinic Name: \_\_\_\_\_      City/State: \_\_\_\_\_

**Clinical Description**

Was the patient ill with typhoid fever? (fever, abdominal pain, headache, etc)    Yes    No    Unk

If yes, \*onset date \_\_\_/\_\_\_/\_\_\_    Time: \_\_\_\_\_ AM / PM

Did the patient have:

Fever	Yes	No	Unk	Diarrhea	Yes	No	Unk	Body aches	Yes	No	Unk
Appetite loss	Yes	No	Unk	Cough	Yes	No	Unk	Other	Yes	No	Unk
Abd. pain	Yes	No	Unk	Headache	Yes	No	Unk				

How many days did the illness last? \_\_\_\_\_ days

Did case receive antibiotics for this illness? Yes No Unk Antibiotic name: \_\_\_\_\_

\*Outcome: Survived Died Unk (FoodNet counties: record pt outcome on 7th day after specimen collect date)

If died, date of death: \_\_\_/\_\_\_/\_\_\_

\*Was patient hospitalized? Yes No Unk (ER visits only not considered "hospitalized")

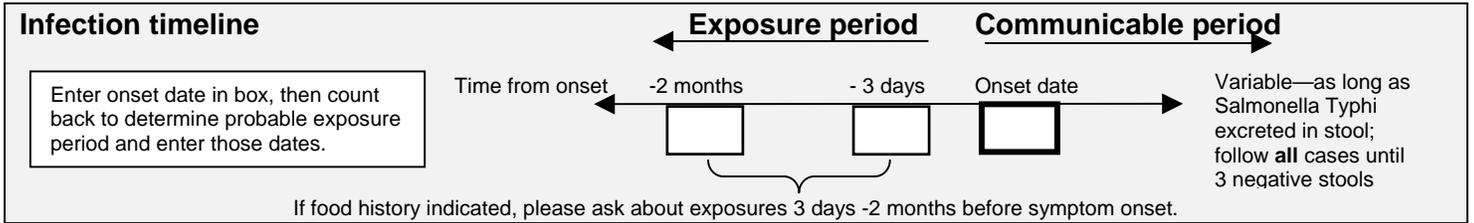
If hospitalized: \*Hospital Name: \_\_\_\_\_

\*Date of Admission: \_\_\_/\_\_\_/\_\_\_

\*Date of Discharge: \_\_\_/\_\_\_/\_\_\_

\*Transferred to another hospital? Yes No Unk

\*Transfer hosp name: \_\_\_\_\_



**Travel information**

\*Did patient travel or live outside the US in the 30 days prior to the onset of illness? Yes No Unk

If yes, Country Date left US Date returned to US

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_
- (4) \_\_\_\_\_

What was the purpose of the international travel?

Business?	Yes	No	Unk	Immigration to the US?	Yes	No	Unk
Tourism?	Yes	No	Unk	Other? specify: _____	Yes	No	Unk
Visit relatives or friends?	Yes	No	Unk				

**Vaccination history**

Did patient receive typhoid vaccination within 5 years before onset of illness? Yes No Unk

If yes, indicate type of vaccine received:

Year received:

Oral Ty21a or Vivotif (Berna) four pill series	Yes	No	Unk	_____
ViCPS or Typhim Vi shot (Pasteur Merieux)	Yes	No	Unk	_____

**School/Work**

Occupation: \_\_\_\_\_

Student? Yes No

Place of Employment: \_\_\_\_\_

If yes, Name of School: \_\_\_\_\_

Does the case...(circle appropriate answer):

Attend, work or volunteer at a child care center / preschool?	Yes	No	Unk
Have a child(ren) in a child care center?	Yes	No	Unk
Attend, work or volunteer at a residential facility? (e.g. nsg home)	Yes	No	Unk

If yes to any of the above,

Name and location of facility \_\_\_\_\_

Are other children/staff ill? Yes No Unk

Provide direct patient care as a health care worker? Yes No Unk  
 If yes, name and location of facility \_\_\_\_\_

Work as a food handler? Yes No Unk  
 If yes, name and location of facility \_\_\_\_\_

Since the case became ill, did case prepare food for any public or private gatherings? Yes No Unk  
 If yes, provide details: \_\_\_\_\_

**Contact management**

Complete the table below for **all** household members and other close contacts. If any of these persons has been ill with similar symptoms, please indicate the date of onset and symptoms.

Name	Age	Occupation/ Child Care	Similar illness	Onset m d y	Comments
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____
_____	_____	_____	Y N U	_____	_____

**If case or household contact of case is high risk (food handler, health care worker, child care) refer to CD manual for restrictions/follow up. Obtain details of site, job description, dates worked/attended during communicable period, supervisor name, etc.**

**If a case reports appropriately-timed international travel then the focus of the rest of the interview should be disease control efforts. If a case has had NO international contact, then an intense investigation should occur to determine the source of the patient's infection. Please contact CDPHE for assistance.**

**Epi-links**

Is any person listed above already a confirmed or suspected case in CEDRS? Yes No Unk If yes, CEDRS# \_\_\_\_\_

Is this patient associated with an outbreak? Yes No Unk If yes, specify: \_\_\_\_\_  
 (typhoid outbreak is defined as ≥ 2 cases associated by time and place)

Was the case traced to a typhoid carrier? Yes No Unk

**Notes:**

**Summary of follow up**

- Arrangements made to follow case until 3 negative stools
- Hygiene education provided
- Work or childcare restriction for case
- Follow up of other household members
- Child care center inspected
- Restaurant inspected
- \_\_\_\_\_

Questions about filling out this form?  
 Contact the Communicable Disease Epidemiology Program at 303-692-2700, 800-866-2759  
**After finishing case interview, update the CEDRS record and FAX this form to CDPHE.**