

SHIGELLOSIS CASE INVESTIGATION FORM

Use this form to interview all reported cases of shigellosis.

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: _____

Contact attempts: record date(s) and contact method (phone, text, letter) here:

Interviewed: Patient Parent/Spouse Refused/Unable to Contact Medical Record Other: _____

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 Unknown

Language spoken: _____ Parent/legal guardian: _____

Residence:

Address: _____

City: _____

County: _____

Zip Code: _____

Phone Numbers:

Home Phone: (____) _____

Work Phone: (____) _____

Mobile: (____) _____

E-mail: _____

Laboratory information *****please confirm lab information with patient, even if already in CEDRS

*Culture: Pos Neg Not tested Serogroup (circle): sonnei flexneri boydii dysenteriae unknown

*PCR: Pos Neg Not tested

Lab or hospital name: _____

*Date specimen(s) collected: ___/___/___

*Specimen source: Stool Urine
Blood Other: _____

Physician Name: _____

MD Phone: (____) _____

Clinic Name: _____

City/State: _____

Clinical Description (Yes=Y; No=N; Unknown=U)

Did the patient have symptoms?: Y N U If yes, *onset date ___/___/___ Time: ___ AM / PM

Did the patient have:

Diarrhea	Y N U	Fever (max temp _____)	Y N U	Headache	Y N U
Date diarrhea onset ___/___/___		Vomiting	Y N U	Body aches	Y N U
Bloody diarrhea	Y N U	Abd. cramps	Y N U	Other _____	Y N U

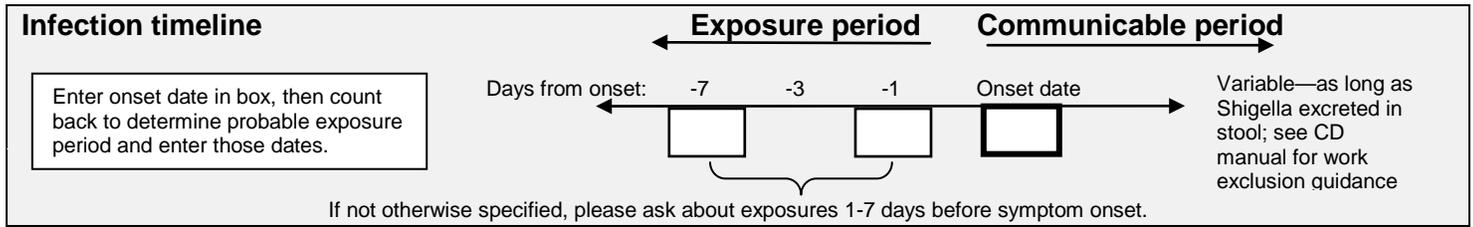
How many days did the illness last? _____ days

Did case receive antibiotics for this illness? Y N U

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: _____



School/Work

Occupation: _____ Student? Yes No
 Place of Employment: _____ If yes, Name of School: _____

During incubation period, did the case work/volunteer/attend a child care setting? Yes No Unk

Since the case became ill, has the case attended, worked or volunteered at a child care center / preschool? Yes No Unk

Have a child(ren) in a child care center? Yes No Unk

If yes to any of the above,

Name and location of facility _____

Are other children/staff ill? 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 residents/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 with others (during 1-3 days prior to illness)

Did patient have contact with any individual who had a diarrheal illness(before case's onset)? Yes No Unk

If yes, which of the following describes the individuals (check all that apply):

- Child attending child care
- Child attending school
- Child, other setting
- Household member, not sexual partner
- Household member and sexual partner
- Male sexual partner
- Female sexual partner
- Other (specify) _____

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	_____	_____

If case or household contact or 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.

Travel information

*Did patient travel outside the US in the 7 days prior to the onset of illness? Yes No Unk
If yes, complete international travel section ONLY and STOP (no other food or other exposure info is necessary; complete the CEDRS record and any necessary disease control activities)

Country	Date left US	Date returned to US	
(1) _____	_____	_____	<input type="checkbox"/> Check box if case was adopted or immigrated to US (no "date left US")
(2) _____	_____	_____	
(3) _____	_____	_____	

Did patient travel within the US in the 7 days prior to the onset of illness? Yes No Unk
If yes, where/when: _____

Water (ask about preceding 1-7 days)

Did patient drink any untreated water from a pond, stream, spring, lake or river? Yes No Unk

Did the patient swim or wade in any of the following types of recreational water? If yes, location / dates:

Lake, pond, river, or stream	Y N U
Ocean	Y N U
Hot tub/spa, whirlpool, Jacuzzi	Y N U
Swimming or wading pool	Y N U
Recreational waterpark or any type of fountain	Y N U
Drainage ditch/irrigation canal	Y N U
Other, specify: _____	

Restaurant history/Group activities

Any group gatherings, picnics, sporting events, etc., during the 7 days before illness? Yes No Unk

Did others accompanying the case become ill with diarrhea, fever, or abdominal pain? Yes No Unk
(If others became ill after a common exposure, this may be an outbreak. Call regional epidemiologist or CDPHE for assistance)

Did patient eat out at any restaurants or other commercial places (i.e., not at a friend's house)? Yes No Unk

<i>If yes,</i> Name	Address	Date of Exposure	Foods Eaten
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Grocery / food store history

List the food store(s) or grocery store(s) for foods consumed during 7 days prior to illness:

Name/location: _____

Name/location: _____

Did patient purchase/consume any food from a farmer's market? Yes No Unk If yes, what/where? _____

Did patient purchase/consume any food from a CSA (community supported agriculture project) or a food coop or a home delivery service (such as a service that delivers fresh produce to your doorstep)?

Yes No Unk If yes, what/where? _____

Did patient purchase/consume any food from a specialty stores? Yes No Unk If yes, what/where? _____
(such as a carniceria, or ethnic market)

Food history Interviewer: if patient is unsure, ask patient if it is likely if s/he ate a particular food item
During 7 days prior to onset of illness:

Any food or drinks with marijuana or its active ingredient THC in them (e.g. brownies, cookies, butter or other foods)?
Y N U

If yes: What food(s) did you eat or drink? _____

Was this food prepared or made at a store? Y N U

Was this food prepared or made at home?(i.e. not retail) Y N U

If at home, was it made with any infused products that were from a store? Y N U

Sexual history (ask both questions for all cases age ≥ 18 years)

Interviewer can read, if desired: Shigella can be spread by food and water but also through sex. I am going to ask you some questions about having sex. I need to ask you these questions even if some may not seem to apply to you. The questions may be sensitive, but your answers will be kept strictly private, and they will help us understand how to do a better job preventing Shigella infections.

During the 7 days before your illness did you have sexual contact with a man? Y N U

During the 7 days before your illness did you have sexual contact with a woman? Y N U

Epi-links

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

Is this patient part of a known/suspected outbreak? Yes No Unk If yes, specify: _____

If case or household contact or 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.

Notes:

Summary of follow up

- 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 Branch at 303-692-2700, 800-866-2759
After finishing case interview, update the CEDRS record. Do NOT send this form to CDPHE unless it is requested (e.g. as part of a suspected outbreak).