

California Department of Public Health  
 Center for Infectious Diseases  
 Division of Communicable Disease Control  
 Infectious Diseases Branch  
 Surveillance and Statistics Section  
 MS 7306, P.O. Box 997377  
 Sacramento, CA 95899-7377

Local ID Number \_\_\_\_\_

(Please use the same ID Number on the preliminary and final reports to allow linkage to the same case.)

Report Status (check one)

Preliminary Final

## LISTERIOSIS CASE REPORT

PATIENT INFORMATION					
Last Name	First Name	Middle Name	Suffix	Primary Language	
<input type="checkbox"/> English		<input type="checkbox"/> Spanish		<input type="checkbox"/> Other: _____	
Social Security Number (9 digits)		DOB (mm/dd/yyyy)	Age	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	
Address Number & Street - Residence			Apartment/Unit Number		
City/Town			State	Zip Code	
Census Tract		County of Residence		Country	
Country of Birth		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Home Telephone		Cellular Phone/Pager		Work/School Telephone	
Gender					
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____					
E-mail Address			Other Electronic Contact Information		
Work/School Location			Work/School Contact		
Pregnant?		If Yes, Est. Delivery Date (mm/dd/yyyy)			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk					
Medical Record Number		If not U.S. Born - Date of Arrival in U.S. (mm/dd/yyyy)			
Occupation Setting (see list on page 7)		Other Describe/Specify			
Occupation (see list on page 7)		Other Describe/Specify			
*Comment: self-identity or self-reporting The response to this item should be based on the patient's self-identity or self-reporting. Therefore, patients should be offered the option of selecting more than one racial designation.					
CLINICAL INFORMATION					
Physician Name - Last Name			First Name		Telephone Number

First three letters of  
patient's last name:

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**SIGNS AND SYMPTOMS**

Symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Onset Date (mm/dd/yyyy)	Date First Sought Medical Care (mm/dd/yyyy)	Duration of Acute Symptoms (days)
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Note: For Signs and Symptoms listed below, please review medical records. This is necessary for proper case classification. If the patient was hospitalized, please provide copy of discharge summary.

Signs and Symptoms	Yes	No	Unk	If Yes, Specify as Noted
Meningitis				
Bacteremia / sepsis				
Febrile gastroenteritis				<i>If Yes, highest temperature (specify °F/°C)</i>
Amnionitis				
Miscarriage / stillbirth				
Pneumonia (neonate)				
Granulomatosis infantisepticum (neonate)				

Other signs / symptoms (specify)

**PAST MEDICAL HISTORY**

Was the patient pregnant at onset? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, weeks gestation
Does the patient take any medications regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify medication(s)
Does the patient have any medical conditions? (i.e., renal disease, diabetes, immune compromising conditions) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify medical condition(s)

**HOSPITALIZATION**

Did patient visit emergency room for illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, how many total hospital nights?
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If there were any ER or hospital stays related to this illness, specify details below.

**HOSPITALIZATION - DETAILS**

Hospital Name 1	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis
Hospital Name 2	Street Address			Admit Date (mm/dd/yyyy)	
	City			Discharge / Transfer Date (mm/dd/yyyy)	
	State	Zip Code	Telephone Number	Medical Record Number	Discharge Diagnosis

First three letters of patient's last name:

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**OUTCOME**

Outcome? <input type="checkbox"/> Survived <input type="checkbox"/> Died <input type="checkbox"/> Unk	If Survived, Survived as of _____ (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
If patient was pregnant, outcome of fetus? <input type="checkbox"/> Stillborn <input type="checkbox"/> Born alive but died within seven days <input type="checkbox"/> Alive, with complications <input type="checkbox"/> Alive and well		

**LABORATORY INFORMATION**

**LABORATORY RESULTS SUMMARY**

Specimen Type <input type="checkbox"/> Blood* <input type="checkbox"/> CSF* <input type="checkbox"/> Placenta <input type="checkbox"/> Stool Other: _____	* If pregnancy-associated, specify if Blood or CSF specimen is from mother or neonate <input type="checkbox"/> Mother <input type="checkbox"/> Neonate		
Collection Date (mm/dd/yyyy)	Results	Laboratory Name	Telephone Number
Was result confirmed by local public health lab? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Result (including subtype)		Local Lab ID Number
Was isolate sent to state lab for serotyping confirmation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Result (including serotype)		State Lab ID Number
Was PFGE requested? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Pattern 1 #	Pattern 2 #	CDC Cluster ID # (if known)

**EPIDEMIOLOGIC INFORMATION**

**INCUBATION PERIOD: 28 DAYS PRIOR TO ILLNESS ONSET**

**EXPOSURES / RISK FACTORS**

If NEONATE / INFANT: Was listeriosis confirmed in mother? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, explain
If NEONATE: Did birth mother have febrile illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, explain

**DID THE PATIENT EAT OR DRINK ANY OF THE FOLLOWING ITEMS DURING THE INCUBATION PERIOD?**

Food Item	Yes	No	Unk	If Yes, Specify as Noted
Cold cuts sliced at a deli, (e.g., turkey breast, ham, pastrami)				Type(s) <span style="float: right;">Where purchased</span>
Pre-packaged cold cuts				Type(s) <span style="float: right;">Brand(s) <span style="float: right;">Where purchased</span></span>
Hot dogs				Type(s) <span style="float: right;">Brand(s)</span>
				Eaten right out of the package? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Refrigerated pâté or meat spreads, not canned				Type(s) <span style="float: right;">Brand(s) <span style="float: right;">Where purchased</span></span>
Refrigerated, smoked, or cured seafood (e.g., salmon, whitefish, trout), not canned				Type(s) <span style="float: right;">Brand(s) <span style="float: right;">Where purchased</span></span>
Raw (unpasteurized) milk				Type(s) <span style="float: right;">Brand(s) <span style="float: right;">Where purchased</span></span>
Raw milk products				Type(s) <span style="float: right;">Brand(s) <span style="float: right;">Where purchased</span></span>
Mexican-style fresh cheese (queso fresco) or cheese from a street vendor				Unpasteurized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				Brand(s) <span style="float: right;">Location(s) Where Cheese Obtained</span>

(continued on page 4)

First three letters of patient's last name:

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Food Item	Yes	No	Unk	If Yes, Specify as Noted
Soft cheese (e.g., Brie, feta, Camembert, goat, blue)				<i>Type(s)</i> <span style="margin-left: 50px;"><i>Brand(s)</i></span> <span style="margin-left: 50px;"><i>Where purchased</i></span>
Ready-to-eat deli style salads (e.g., potato salad, pasta salad, tuna salad)				<i>Type(s)</i> <span style="margin-left: 50px;"><i>Brand(s)</i></span> <span style="margin-left: 50px;"><i>Where purchased</i></span>
Pre-prepared dips (e.g., hummus)				<i>Type(s)</i> <span style="margin-left: 50px;"><i>Brand(s)</i></span> <span style="margin-left: 50px;"><i>Where purchased</i></span>
Other food exposures of interest				<i>Specify food item(s)</i>

**FOOD HISTORY - GROCERIES**

**WHERE DID PATIENT SHOP FOR GROCERIES? (INCLUDE FARMER'S MARKETS, DELIS, SWAP MEETS, ETC.)**

<i>Store / Location 1</i>	<i>Address / Cross-streets</i>		
	<i>City</i>	<i>State</i>	
<i>Store / Location 2</i>	<i>Address / Cross-streets</i>		
	<i>City</i>	<i>State</i>	
<i>Store / Location 3</i>	<i>Address / Cross-streets</i>		
	<i>City</i>	<i>State</i>	

**FOOD HISTORY - OUTSIDE HOME**

*Did the patient consume food or drink prepared outside of the home during the incubation period?*  
Yes No Unk

*If Yes, specify name of place (e.g., restaurant, concession stand, friend's house, etc.), location, date, and items consumed below.*

**FOOD HISTORY - OUTSIDE HOME - DETAILS**

<i>Name of Place 1</i>	<i>Location (city, state)</i>		<i>Date (mm/dd/yyyy)</i>
	<i>Items Consumed</i>		
<i>Name of Place 2</i>	<i>Location (city, state)</i>		<i>Date (mm/dd/yyyy)</i>
	<i>Items Consumed</i>		
<i>Name of Place 3</i>	<i>Location (city, state)</i>		<i>Date (mm/dd/yyyy)</i>
	<i>Items Consumed</i>		
<i>Name of Place 4</i>	<i>Location (city, state)</i>		<i>Date (mm/dd/yyyy)</i>
	<i>Items Consumed</i>		

First three letters of patient's last name:

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**TRAVEL HISTORY**

Did patient travel <b>outside county of residence</b> during the incubation period? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify all locations and dates below.
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**TRAVEL HISTORY - DETAILS**

Location (city, county, state, country)	Date Travel Started (mm/dd/yyyy)	Date Travel Ended (mm/dd/yyyy)

**ILL CONTACTS**

Any contacts with similar illness (including household contacts)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	If Yes, specify details below.
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**ILL CONTACTS - DETAILS**

Name 1	Age	Gender	Telephone Number	Type of Contact / Relationship		
	Street Address			Date of Contact (mm/dd/yyyy)	Illness Onset Date (mm/dd/yyyy)	
	City	State	Zip Code	Exposure Event		
Name 2	Age	Gender	Telephone Number	Type of Contact / Relationship		
	Street Address			Date of Contact (mm/dd/yyyy)	Illness Onset Date (mm/dd/yyyy)	
	City	State	Zip Code	Exposure Event		

**NOTES / REMARKS**


First three letters of  
patient's last name:

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<b>REPORTING AGENCY</b>			
<i>Investigator Name</i>	<i>Local Health Jurisdiction</i>	<i>Telephone Number</i>	<i>Date (mm/dd/yyyy)</i>
<i>First Reported By</i> <input type="checkbox"/> Clinician <input type="checkbox"/> Laboratory <input type="checkbox"/> Other (specify): _____			
<b>EPIDEMIOLOGICAL LINKAGE</b>			
<i>Epi-linked to known case?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>Contact Name / Case Number</i>		
<b>DISEASE CASE CLASSIFICATION</b>			
<i>Case Classification (see case definition below)</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect			
<i>Neonatal or Non-Neonatal*</i> <input type="checkbox"/> Neonatal <input type="checkbox"/> Non-Neonatal	<i>*Note that infected pregnant women and/or their infected offspring are to be designated as "Neonatal" cases.</i>		
<i>Nosocomial or Community Acquired</i> <input type="checkbox"/> Nosocomial <input type="checkbox"/> Community acquired	<i>Specify if Foodborne</i> <input type="checkbox"/> Foodborne		
<b>OUTBREAK</b>			
<i>Part of known outbreak?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<i>If Yes, extent of outbreak</i> <input type="checkbox"/> One CA jurisdiction <input type="checkbox"/> Multiple CA jurisdictions <input type="checkbox"/> Multistate <input type="checkbox"/> International <input type="checkbox"/> Unk <input type="checkbox"/> Other (specify): _____		
<i>Mode of Transmission</i> <input type="checkbox"/> Point source <input type="checkbox"/> Person-to-person <input type="checkbox"/> Unk <input type="checkbox"/> Other: _____	<i>Vehicle of Outbreak</i>	<i>Pattern 1 ID number</i>	<i>Pattern 2 ID number</i>
<b>STATE USE ONLY</b>			
<i>State Case Classification</i> <input type="checkbox"/> Confirmed <input type="checkbox"/> Not a case <input type="checkbox"/> Need additional information			
<b>CASE DEFINITION</b>			
<b><u>LISTERIOSIS (2010)</u></b>			
CLINICAL DESCRIPTION			
In adults, invasive disease caused by <i>Listeria monocytogenes</i> manifests most commonly as meningitis or bacteremia; infection during pregnancy may result in fetal loss through miscarriage or stillbirth, or neonatal meningitis or bacteremia. Other manifestations can also be observed.			
LABORATORY CRITERIA FOR DIAGNOSIS			
A. Isolation of <i>L. monocytogenes</i> from a normally sterile site (e.g., blood or cerebrospinal fluid [CSF] or, less commonly, joint, pleural, or pericardial fluid)			
B. In the setting of miscarriage or stillbirth, isolation of <i>L. monocytogenes</i> from placental or fetal tissue			
CASE CLASSIFICATION			
- <b>Confirmed:</b> A clinically compatible case that is laboratory-confirmed			
COMMENT			
The usefulness of other laboratory methods such as fluorescent antibody testing or polymerase chain reaction to diagnose invasive listeriosis has not been established.			

<b>RACE DESCRIPTIONS</b>	
<b>Race</b>	<b>Description</b>
American Indian or Alaska Native	Patient has origins in <b>any</b> of the original peoples of North and South America (including Central America).
Asian	Patient has origins in <b>any</b> of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., including Bangladesh, Cambodia, China, India, Indonesia, Japan, Korea, Malaysia, Nepal, Pakistan, the Philippine Islands, Thailand, and Vietnam).
Black or African American	Patient has origins in <b>any</b> of the black racial groups of Africa.
Native Hawaiian or Other Pacific Islander	Patient has origins in <b>any</b> of the original peoples of Hawaii, Guam, American Samoa, or other Pacific Islands.
White	Patient has origins in <b>any</b> of the original peoples of Europe, the Middle East, or North Africa.
<b>OCCUPATION SETTING</b>	
<ul style="list-style-type: none"> <li>• Childcare/Preschool</li> <li>• Correctional Facility</li> <li>• Drug Treatment Center</li> <li>• Food Service</li> <li>• Health Care - Acute Care Facility</li> <li>• Health Care - Long Term Care Facility</li> <li>• Health Care - Other</li> </ul>	<ul style="list-style-type: none"> <li>• Homeless Shelter</li> <li>• Laboratory</li> <li>• Military Facility</li> <li>• Other Residential Facility</li> <li>• Place of Worship</li> <li>• School</li> <li>• Other</li> </ul>
<b>OCCUPATION</b>	
<ul style="list-style-type: none"> <li>• Adult film actor/actress</li> <li>• Agriculture - farmworker or laborer (crop, nursery, or greenhouse)</li> <li>• Agriculture - field worker</li> <li>• Agriculture - migratory/seasonal worker</li> <li>• Agriculture - other/unknown</li> <li>• Animal - animal control worker</li> <li>• Animal - farm worker or laborer (farm or ranch animals)</li> <li>• Animal - veterinarian or other animal health practitioner</li> <li>• Animal - other/unknown</li> <li>• Clerical, office, or sales worker</li> <li>• Correctional facility - employee</li> <li>• Correctional facility - inmate</li> <li>• Craftsman, foreman, or operative</li> <li>• Daycare or child care attendee</li> <li>• Daycare or child care worker</li> <li>• Dentist or other dental health worker</li> <li>• Drug dealer</li> <li>• Fire fighting or prevention worker</li> <li>• Flight attendant</li> <li>• Food service - cook or food preparation worker</li> <li>• Food service - host or hostess</li> <li>• Food service - server</li> <li>• Food service - other/unknown</li> <li>• Homemaker</li> <li>• Laboratory technologist or technician</li> <li>• Laborer - private household or unskilled worker</li> <li>• Manager, official, or proprietor</li> <li>• Manicurist or pedicurist</li> <li>• Medical - emergency medical technician or paramedic</li> <li>• Medical - health care worker</li> </ul>	<ul style="list-style-type: none"> <li>• Medical - medical assistant</li> <li>• Medical - pharmacist</li> <li>• Medical - physician assistant or nurse practitioner</li> <li>• Medical - physician or surgeon</li> <li>• Medical - nurse</li> <li>• Medical - other/unknown</li> <li>• Military</li> <li>• Police officer</li> <li>• Professional, technical, or related profession</li> <li>• Retired</li> <li>• Sex worker</li> <li>• Stay at home parent/guardian</li> <li>• Student - preschool or kindergarten</li> <li>• Student - elementary or middle school</li> <li>• Student - high school</li> <li>• Student - college or university</li> <li>• Student - other/unknown</li> <li>• Teacher/employee - preschool or kindergarten</li> <li>• Teacher/employee - elementary or middle school</li> <li>• Teacher/employee - high school</li> <li>• Teacher/instructor/employee - college or university</li> <li>• Teacher/instructor/employee - other/unknown</li> <li>• Unemployed - seeking employment</li> <li>• Unemployed - not seeking employment</li> <li>• Unemployed - other/unknown</li> <li>• Volunteer</li> <li>• Other</li> <li>• Refused</li> <li>• Unknown</li> </ul>